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INTRODUCTION

This document is the Summary Plan Description and Master Plan Document for the City of Asheville Employee Benefit Plan (the "Plan"). The Plan is designed and maintained by City of Asheville (referred to as "Employer" or "Plan Sponsor") to provide health care benefits in the event of injury or sickness to covered employees and dependents.

Coverage under the Plan for an employee and the employee's designated dependents will become effective when the employee and such dependents satisfy the waiting period and all the eligibility requirements of the Plan. Covered employees and dependents are referred to as "members."

The Plan uses a preferred provider network. The network is a group of providers (physicians, hospitals and other health care professionals) contracted to offer health care services at reduced rates to Plan members. Members will be able to choose at any time from the list of preferred providers, or they may obtain health care from a non-network provider. When a member uses a preferred provider, the Plan will pay a larger portion of the covered medical expenses. As a result of the lower contracted rates and the higher benefit rate paid by the Plan, the member will save on health care expenses. However, the member will always have the option to use any health care provider he/she prefers.

The members should review this booklet carefully, especially the sections pertaining to Care Management Services and Special Provisions. These sections describe certain steps that must be taken before receiving care in order to receive the maximum benefit available under the Plan. Certain services must be pre-approved in order for the member to receive the maximum benefit. If these services are not pre-approved, benefits will not be paid or will be paid at a lower rate, and a penalty may apply.

City of Asheville intends to maintain this Plan indefinitely. However, it reserves the right to modify, amend or terminate the Plan at any time. If the Plan, or any benefit under the Plan, is modified, amended or terminated, the rights of covered persons are limited to covered charges incurred before the modification, amendment, or termination. (See "Amending and Terminating the Plan" in the General Information section).

The terms of the Plan will be construed and administered to meet the minimum requirements of all applicable federal laws. To the extent a Plan provision is contrary to or fails to address the minimum requirements of an applicable federal law, the Plan shall provide the coverage or benefit necessary to comply with such minimum requirements.

PLAN INFORMATION

EMPLOYER ID NUMBER: 56-6000224

PLAN NUMBER: 501

PLAN EFFECTIVE DATE: 1/1/01

PLAN REVISION DATE: 1/1/07

EMPLOYEE GROUPS COVERED
IN THIS SUMMARY:
This Summary Plan Description and Master Plan Document applies to all eligible employees of City of Asheville and its participating subsidiaries.

EMPLOYER/PLAN SPONSOR/PLAN ADMINISTRATOR:

City of Asheville
P.O. Box 7148
Asheville, NC 28802
(828) 259-5690

AGENT FOR SERVICE OF LEGAL PROCESS:
The Plan Administrator named above is the agent for service of legal process.

PLAN SUPERVISOR:

Primary PhysicianCare, Inc.
P.O. Box 11088
Charlotte, NC 28220-1088
(704) 523-2758

PLAN YEAR/CALENDAR YEAR:
The financial records of the Plan are kept on a plan year basis. The plan year will begin each **January 1** and end on **December 31.** Deductible and co-insurance information is maintained on a calendar year basis.

TYPE OF ADMINISTRATION:
The Plan Administrator has complete power and discretionary authority to manage and administer the Plan. The Plan Administrator may delegate any assigned administrative duties to one or more designated persons or entities. Processing of initial claims has been delegated to the Plan Supervisor; however, the duties of the Plan Supervisor are merely ministerial in nature and no discretionary authority or responsibility for the Plan has been conferred or delegated to the Plan Supervisor.

Plan Benefits

The Plan is an employee welfare benefits plan providing medical benefits. The Plan provides benefits only for those covered medical expenses specifically listed in this Summary Plan Description (See the Schedule of Benefits and Covered Medical Expenses sections.)

Funding

The Plan is funded by contributions from the Plan Sponsor and covered employees. The Plan Sponsor determines the level of contributions required, if any, from each participant and reserves the right to evaluate and modify the level of contributions from time to time. The application for enrollment and coverage authorizes the Plan Sponsor to make any required payroll deductions.

HIPAA Privacy Official

Questions about the Plan's privacy policies and procedures and privacy complaints must be directed to:

City of Asheville
Privacy Official
P.O. Box 7148
Asheville, NC 28802
(828) 259-5690

ELIGIBILITY

ELIGIBILITY REQUIREMENTS

Requirements for Employee Coverage: You are eligible for employee coverage as of the date that you satisfy each of the following requirements:

1. You are a part-time or full-time employee of the Employer. You will be considered part-time if you are regularly scheduled to work at least **twenty (20) hours** per week and full-time if you are regularly scheduled to work at least **thirty-seven and a half (37.5) hours** per week and you are on the regular payroll of the Employer; and
2. You are in a class eligible for coverage under the Plan; and
3. You complete the employment-waiting period of **thirty (30) days** as an active employee. A "waiting period" is the time between the first day of employment and the first day of coverage under the Plan. Absences due to health reasons will be disregarded in determining whether you have satisfied the waiting period. Coverage is effective on the **first day following** the waiting period.

The Mayor and members of the Asheville City Council are eligible for coverage on the day of enrollment following their first day of service in their elected office. Dependent coverage is also available for any eligible dependents

Requirements for Retiree Coverage: If an employee retires from active service for the employer after having completed at least five (5) years of service they will be eligible for coverage. Dependent coverage will also be available for eligible dependents of retirees if covered at the time of retirement. Coverage is available until the retiree reaches age sixty-five (65) or is deceased at which time the employee and/or his or her dependents may be eligible for COBRA continuation coverage if he or she is under age sixty-five (65). For a complete explanation of COBRA availability, see the section entitled COBRA Continuation Coverage.

Requirements for Dependent Coverage: A family member of an employee will become eligible for dependent coverage on the first day that the employee is eligible for employee coverage and the family member satisfies the requirements for dependent coverage.

Dependents eligible for coverage include:

- The employee's married spouse. *Spouse is defined as a person of the opposite sex, who is a husband or wife*;
  - ♦ If a working spouse of a covered employee has access to healthcare benefits through his/her Employer Plan, then the spouse must elect that coverage in order to be covered under City of Asheville's plan.
  - ♦ If a part-time employee is employed full-time by another employer and has access to healthcare benefits through his/her full-time Employer Plan, then the employee must elect that coverage in order to be covered under City of Asheville's plan.
- The employee's unmarried child (ren) under the age of nineteen (19), including:
  - ♦ A natural born child;

- ♦ An adopted child or a child placed with the employee in anticipation of adoption. A "child placed with an employee in anticipation of adoption" refers to a child whom the employee intends to adopt, whether or not the adoption has become final, provided that the child has not attained the age of eighteen (18) as of the date of placement for adoption. The term "placed for adoption" means the assumption and retention by the employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption, and the legal process must have commenced and be documented;
- ♦ A child for whom the employee has legal guardianship and who is primarily dependent upon the employee for support and resides with the employee; and
- ♦ A stepchild or foster child who is primarily dependent upon the employee for support and resides with the employee;

- An employee's unmarried child of any age who is mentally or physically incapable of earning his or her own living due to permanent, chronic, and total disability. The child may obtain continued coverage if, within thirty-one (31) days after the date coverage would otherwise terminate, the employee submits proof of the child's incapacity (See Eligibility for Disabled Children).
- An employee's unmarried child up to his or her twenty-fifth (25th) birthday, provided the child is a full-time student and is primarily dependent upon the employee for support (See Eligibility for Full-Time Students).

NOTE: The phrase "primarily dependent upon" shall mean dependent upon the covered employee for support and maintenance as defined by the Internal Revenue Code, and the covered employee must declare the child as a dependent for purposes of taking an income tax exemption. The Plan Administrator may require documentation proving dependency, including birth certificates, tax records, or initiation of legal proceedings severing parental rights.

At any time, the Plan may require proof that a spouse or a child qualifies or continues to qualify as a dependent as defined by this Plan. If both husband and wife are employees, their children will be covered as dependents of the husband or wife, but not of both.

Any child of a Plan participant who is an alternate recipient under a Qualified Medical Child Support order shall be considered as having a right to dependent coverage under this Plan with no Pre-existing Condition provisions applied. A participant of the Plan may obtain from the Plan Administrator, without charge, a copy of the procedures governing qualified medical support order (QMCSO) determinations.

Eligibility for Disabled Children: In order for a disabled child to be eligible for coverage under the Plan beyond the child's nineteenth ($19^{th)}$ birthday, the child:

- Must be enrolled in the Plan prior to the age of nineteen (19);
- Must be incapable of self-support because of mental retardation or permanent, chronic, and total disability which commenced prior to the age of nineteen (19) or prior to the age of twenty-five (25) if he or she is a full-time student;
- Must be primarily dependent upon the employee;
- Must be continuously disabled and covered thereafter; and
- Must be considered disabled by the Social Security Administration.

If you believe a covered dependent meets the disability criteria above you may obtain a determination of disability from the Social Security Administration. This information must be submitted to the Plan Administrator within thirty-one (31) days prior to the covered dependent reaching the age of nineteen (19) or prior to the covered dependent reaching the age of twenty-five (25) if he or she continues as a full-time student. You may be required to submit additional information necessary for completion of the eligibility determination.

If such eligibility is approved, you may be further required (usually not more frequently than once a year) to furnish satisfactory evidence to substantiate the continued eligibility of the covered dependent under the Plan.

Eligibility of Full-Time Students: In order for a dependent child to be eligible for benefits under the Plan as a full-time student beyond the age of nineteen (19) and to his or her twenty-fifth (25^{th}) birthday, the dependent child:

- Must not be employed on a regular full-time basis;
- Must not be covered under any employee group insurance or prepayment plan other than either parent's group coverage,
- Must be enrolled full-time in a recognized course of study or training at an accredited learning institution such as a:
  - high school or vocational school supported or operated by the local, state, or federal government,
  - state university, college, or community college,
  - licensed private school, college, or university.
- Must be in active, full-time attendance at the time the service is provided for which the benefit is claimed. "Full-time" for the purposes of this provision is defined as being enrolled in the number of hours, credits or courses considered full-time by the accredited educational institution that the student is attending.

A covered dependent who is a full-time student must submit a letter from the registrar's office to the Plan Administrator once per school term, when the new term begins, indicating the student's name, full-time student status and the semester enrolled.

Coverage of a dependent who qualifies as a full-time student will continue during regularly scheduled vacation periods or between-term periods as established by the institution. Dependent status will terminate on the date the school reconvenes if attendance does not resume unless cessation is due to an illness or injury which prevents full-time attendance. In this case, status shall terminate on the first date of the school's next regular session. Work limited to vacations and between-terms is not considered employment on a regular, full-time basis.

Persons Excluded as Non-Dependents: The term "dependent" excludes:

- any individuals living in the covered employee's home who do not satisfy the eligibility requirements for dependents as defined by the Plan;
- the legally separated spouse of the employee, unless coverage is required due to court order or decree ;
- the divorced former spouse of the employee
- any person who is on active duty in any military service of any country; or
- any person who is covered under the Plan as an employee.

An employee's stepchildren or foster children and children for whom the employee has legal guardianship are not eligible for coverage under the Plan unless the children live in the employee's permanent residence.

If a person covered under this Plan changes his or her status from employee to dependent or dependent to employee, and the person is covered continuously under this Plan before, during, and after the change in status, credit will be given for deductibles and all amounts applied to benefit maximums.

ENROLLMENT REQUIREMENTS

Enrollment
An eligible employee must enroll for coverage by filling out and signing an enrollment application. The covered employee is also required to enroll for dependent coverage, if dependent coverage is desired.

Under the Plan, members are classified as "timely," "late" or "special" enrollees depending on when they satisfy enrollment requirements.

Timely Enrollment
Enrollment is "timely" if the completed enrollment form is received by the Plan Administrator no later than thirty-one (31) days after the person first becomes eligible for coverage, either initially or under a special enrollment period. If the enrollment form is not submitted within this deadline, the person will be a "late enrollee" and will have to wait until the next annual open enrollment period to enroll, unless he experiences an event permitting mid-year enrollment (See Mid-Year Enrollment Changes).

Open Enrollment
The Plan includes an annual Open Enrollment period. Eligible employees failing to enroll when initially eligible can enroll as "late enrollees" during Open Enrollment without having to satisfy the special enrollment requirements. In addition, members may elect to make changes in their benefit selections during the Open Enrollment period. Changes in enrollment elections will become effective as of the first day of the plan year following the Open Enrollment period. Enrollment elections will remain in effect for the entire plan year and cannot be changed unless the employee experiences certain events that permit mid-year changes (See Mid-Year Enrollment Changes). Members who fail to make an election during Open Enrollment will automatically retain their present benefit elections. Annual Open Enrollment will take place during the month of November for a January 1st effective date.

Late Enrollment
An enrollment is "late" if it is not "timely" that is, if the enrollment is not completed within thirty-one (31) days after the person first becomes eligible to enroll or during a special enrollment period. Generally, late enrollees may enroll in the Plan only during an Open Enrollment (See Open Enrollment above).

Special Enrollment
If an employee or the employee's dependents are eligible but not already enrolled in the Plan, the employee may request "special enrollment" in the Plan upon either (1) the loss of other health plan coverage or (2) the addition of a new dependent.

Loss of Other Health Plan Coverage: An employee or a dependent who is eligible, but not enrolled in this Plan, may enroll if all of the following conditions are met:

1. The employee or dependent was covered under another group health plan or had health insurance coverage at the time the individual first became eligible for coverage under this Plan.
2. The employee stated in writing at the time Plan coverage was initially offered that the other health coverage was the reason for declining enrollment in this Plan, or the employee provided sufficient documentation of coverage under another plan at the time the initial decision to decline coverage was made.
3. The other coverage of the employee or dependent ended because:
   (a) The other coverage was COBRA continuation coverage that was exhausted. COBRA continuation coverage is considered exhausted when it ceases for any reason other than the person's failure to pay premiums on a timely basis or for improper or illegal acts (such as making a fraudulent claim or an intentional misrepresentation).
   (b) The other health coverage was not COBRA continuation and was terminated due either to loss of eligibility for the coverage (due to legal separation, divorce, death, termination of employment, or reduction in number of hours of employment) or because employer contributions for the other coverage were terminated. An individual will not have special enrollment rights if the other coverage ended due to the individual's failure to pay premiums on a timely basis or for cause (such as making fraudulent claims or intentional misrepresentations).
   (c) The employee or dependent incurs a claim that will meet or exceed a lifetime limit on all benefits. This right continues until at least thirty-one (31) days after the earliest date that a claim is denied due to the lifetime limit.
   (d) The employee or dependent is in a class of coverage that is no longer eligible under the terms of the other Plan.
4. The employee submits a request for special enrollment in writing to the Plan Administrator no later than thirty-one (31) days after the date the other coverage terminates. Coverage will be effective no later than the first day of the month following the date the special enrollment request is received.

Newly-Acquired Dependents: An employee's newly-acquired dependents may enroll in this Plan if:

1. The employee is a participant under this Plan or, if not a participant at the time, the employee has met the waiting period applicable to becoming a participant and is eligible to be enrolled under this Plan; and
2. The person becomes a dependent of the employee through marriage, birth, adoption, or placement for adoption.

If the employee is not yet a participant, the employee must enroll during the Special Enrollment Period in order for the newly acquired dependent to be eligible for coverage. In the case of birth or adoption of a child, the spouse of the covered employee may be enrolled as a dependent of the covered employee if the spouse is eligible for coverage.

The Special Enrollment Period is a period of not more than thirty-one (31) days that begins on the date of the marriage, birth, adoption, or placement for adoption.

The coverage of the employee or dependent enrolled during the Special Enrollment Period will be effective:

1. In the case of marriage, not later than the first day of the first month following the date that the completed request for enrollment is received by the Plan Administrator;
2. In the case of a dependent's birth, as of the date of birth; or
3. In the case of a dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

The "enrollment date" for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the dates a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a waiting period for purposes of the Plan's Pre-Existing Condition exclusion provisions.

Mid-Year Enrollment Changes

Once enrollment elections are made, either during the initial or Special Enrollment periods or during an annual Open Enrollment period, those elections may not be changed and will remain in effect for the entire plan year. However, there are some important exceptions:

1. **Change in Status**

   Employees may revoke or modify their enrollment elections mid-year only if they experience a Change in Status that affects their eligibility or the eligibility of their dependents under this Plan. A "Change in Status" is one of the following events:

   - **Change in legal marital status,** including marriage, death of spouse, divorce, legal separation or annulment;
   - **Change in number of dependents,** including birth, adoption, placement for adoption, and death of a spouse or other dependent;
   - **A dependent satisfying or ceasing to satisfy the requirements for coverage** for unmarried dependents due to age, student status, or any other circumstance;
   - **Change in employment status** of the employee, the employee's spouse or other dependent, including termination or commencement of employment, taking or returning from an unpaid leave of absence, change in work site, change in full-time or part-time status, change in hourly or salaried status;or
   - **Change in residence** by the employee, the spouse or dependent.

   An election change will be approved only if it is consistent with the Change in Status. An election change is "consistent with" a Change in Status if the change is both the result of and corresponds with the Change in Status. For example, if a child ceases to be eligible for coverage because of age, it would be consistent with the Change in Status to drop coverage for the child. However, it would <u>not</u> be consistent with the Change in Status to drop coverage for the employee. As another example, if a spouse is covered under the medical plan of the spouse's employer, and the spouse loses coverage under that plan because of a change from full-time to part-time employment, it would be consistent with the Change in Status for the employee to elect to add the spouse under this Plan.

2. **Change in Cost or Coverage**
   If the cost of benefits increases or decreases during a benefit period, the Plan Sponsor may automatically change employee premium contributions. When the change in cost is significant, employees will be given the opportunity to either increase their contributions or elect a less-costly option (if available)

   If there is a significant overall reduction in the Plan's coverage, employees may elect another benefit option (if available). If a new benefit option is added under the Plan, employees will have the right to change their election to the new benefit option.

3. **Qualified Medical Child Support Order ("QMCSO")**
   A QMCSO is a judgment, decree or order resulting from a divorce, legal separation, annulment or change in custody that requires health coverage for an employee's child. An employee may change his or her Plan enrollment elections if the employee becomes subject to a QMCSO that requires the employee to provide (or cancel) health care coverage for a child.

4. **Entitlement to Medicare or Medicaid**
   An employee may change his or her elections for Plan coverage if the employee or any dependent becomes entitled to or loses Medicare or Medicaid coverage.

How to Make Mid-Year Enrollment Changes

If an employee experiences an event that allows the employee to make a mid-year enrollment change, the employee must submit a completed Enrollment Change Form to the Plan Administrator no later than thirty-one (31) days after the event occurs. If the employee does not request the coverage change within the specified time limit, the employee will lose the right to make a change allowed by that event.

If approved, the employee's enrollment change(s) will take effect:

1. On the date of the event, in the case of a birth, adoption or placement for adoption;
2. No later than the first day of the month following the date the Plan Administrator receives the employee's completed Enrollment Change Form, in the case of all other enrollment changes.

TERMINATION OF COVERAGE

Employee Coverage Termination: Employee coverage will terminate on the earliest of the following dates:

1. The date employment is terminated; or
2. The date on which the covered employee ceases to be in a class eligible for coverage; or
3. The date on which this Plan is terminated; or in case of any benefit under this Plan, the date of termination of the specific benefit; or
4. The date following the day the covered employee dies; or
5. The date the covered employee enters the military service of any country or international organization on a full-time active duty basis other than scheduled drills or other training not exceeding one (1) month in any calendar year; or
6. The date the covered employee fails to make any required contribution for coverage.
7. The date the employee transfers to coverage under a Health Maintenance Organization (HMO);

A covered employee may be eligible for COBRA continuation coverage. For a complete explanation of COBRA availability, see the section entitled COBRA Continuation Coverage.

Coverage Continuation During Periods of Employer-Certified Disability, Leave of Absence, or Layoff: A person may remain eligible for a limited time if active, full-time work ceases due to disability, leave of absence, or layoff. This continuation will end as follows:

1. **For Disability leave only.** The end of the **twelve (12)** calendar month period immediately following the month in which the person last worked as an active employee.
2. **For Leave of Absence or Layoff only.** On the last date that the employee exhausts all available PTO days or at the end of the **twelve (12)** calendar month period immediately following the month in which the person last worked as an active employee, whichever comes first.

While continued, coverage will remain the same as the coverage in effect on the employee's last day worked as an active employee. However, if benefits are modified or reduced for others in the employee's class, benefits will also be modified or reduced for the continued person.

Coverage Continuation During Family and Medical Leave: Regardless of the leave policies described elsewhere in this Plan, this Plan will at all times comply with the Family and Medical Leave Act of 1993 and applicable regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act (FMLA), the employer will maintain coverage under this Plan under the same terms and conditions as coverage, which would have been provided if the covered employee had been continuously employed during the entire leave period. The employee will continue paying any required contributions during the leave.

If Plan coverage is discontinued during the FMLA leave (either upon the employee's election or for failure to pay required contributions during the leave), coverage will be reinstated for the employee and his or her covered dependents if the employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person had coverage under this Plan when the FMLA leave started and will be reinstated to the same extent as the coverage that was in force when coverage was discontinued. For example, Pre-Existing Conditions limitations and other waiting periods will not be imposed unless they were in effect for the employee and/or the employee's dependents when Plan coverage was discontinued for the period of leave.

Rehiring a Terminated Employee: A terminated employee who is rehired will be treated as a new hire and be required to satisfy all eligibility and enrollment requirements, except for an employee returning to work directly from COBRA coverage. In that instance an employee does not have to satisfy Pre-Existing Conditions provisions.

Employees on Military Leave: Employees entering into or returning from military service will have the rights mandated by the Uniformed Services Employment and Reemployment Rights Act ("USERRA"). These rights include up to twenty-four (24) months of extended health care coverage upon payment of the entire cost of coverage plus a reasonable administration fee, and immediate coverage with no Pre-Existing Conditions exclusions applied upon return from military service. These rights apply only to employees and their dependents covered under the Plan before active military service begins.

Plan exclusions and waiting periods may be imposed for any sickness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

Termination of Dependent Coverage: A dependent's coverage will terminate on the earliest of these dates:

1. The date on which the covered dependent ceases to be an eligible dependent; or
2. The date the covered employee's coverage under this Plan terminates; or
3. The date on which the covered employee ceases to be in a class eligible for dependent coverage; or
4. The date this Plan is terminated; in the case of any covered dependent's benefit under this Plan, the date of termination of such benefit; or
5. The date the covered dependent enters the military service of any country or international organization on a full-time active duty basis other than scheduled drills or other training not exceeding one month in any calendar year; or
6. The date the covered employee fails to make any required contribution for dependent coverage.

A covered dependent may be eligible for COBRA continuation coverage. For a complete explanation of COBRA availability, see the section entitled COBRA Continuation Coverage.

Certificate of Creditable Coverage

When coverage for an employee or dependent terminates, a certificate of creditable coverage will be mailed to the individual's last known address. A certificate also will be provided if requested within twenty-four (24) months of the termination of coverage. A certificate of creditable coverage may be needed to reduce any pre-existing condition exclusions upon enrollment in another health plan or policy.

HIGH OPTION PLAN SCHEDULE OF BENEFITS

Medical Care Benefits

When injury or illness cause you or your dependents, while covered under this Plan, to incur Covered Medical Expenses, the Plan will determine benefits according to the provisions described in this Summary Plan Description and Master Plan Document. Benefits for each Covered Medical Expense will be calculated as follows:

1. The lesser of the actual, negotiated or Reasonable & Customary fee will be determined.
2. The amount will be reduced by any applicable deductible or co-pay and multiplied by the appropriate co-insurance level, resulting in the benefit payable.
3. The benefit payable will be subject to the maximums shown on the Schedule of Benefits.

Care Management Features

Your Plan includes one or more features to help control the cost of medical care coverage. Some features will affect the amount of benefits payable for covered expenses. (See the Care Management Services section for details).

Please note that the Plan is not directly involved in treatment, but only provides benefits for services that are covered under the terms of the Plan. Therefore, the Plan has no liability for the quality of care you may receive. You and your health care provider(s) are responsible for making all decisions regarding your health care and will control the course of treatment followed.

Preferred Provider Network

The Plan uses a preferred provider network. "Preferred providers" are contracted either directly by the Plan or through a preferred provider network supplementary to the Plan. A "non-preferred provider" is one who has not elected to participate as a preferred provider in the Plan. A listing of preferred providers is available on-line at www.primarypc.com, or you may request a copy from the Plan Administrator.

Two different levels of benefits are provided under the Plan:

1. The "Preferred" benefit level will be payable for services rendered by a participating provider, and
2. The "Non-Preferred" benefit level will be payable for services rendered by a provider who is not a participating provider.

If a covered person receives emergency care inside or outside of the network service area, the Plan will pay benefits according to the out-of-area benefits shown in the Schedule of Benefits. Travel Network: If you are out of town for business or pleasure, or if you are a dependent college student living away from home, and need medical attention, simply get the care you need. Notify Primary PhysicianCare as soon as possible after the treatment and they will work to negotiate a reduced, discounted rate. These out-of-area charges will be considered as an in-network visit.

Pre-certification

Hospital admissions require pre-certification. If pre-certification is not obtained, a penalty will apply and benefits will be reduced and/or denied. (See the Care Management Services section for details).

Standard Organ Transplant Benefit

If a covered person does not meet all the requirements outlined in the Organ Transplant Program under Care Management Services, the co-insurance rate is 50% with a maximum benefit of $100,000 per transplant procedure.

Calendar Year Deductible

A covered person's deductible requirement will be met when Covered Medical Expenses incurred by that person, while covered during each calendar year, equal the deductible amount. You are responsible for paying the calendar year deductible. The Plan will not reimburse you for this expense. Co-pays, non-covered charges and separate hospital deductibles do not accumulate toward the calendar year deductible.

	Preferred	**Non-Preferred**
Individual	$0	$1,000
Family	$0	$3,000

Co-Insurance Rate

Co-Insurance rate is the percentage of Covered Medical Expenses payable by the Plan after the deductible requirement is met. The co-insurance rate for each type of service is listed in the Schedule of Benefits.

Co-Insurance Limit

Once the covered person has satisfied the required calendar year deductible requirement, the Plan will share the payment of covered charges according to the co-insurance rates listed in the Schedule of Benefits.

The Plan pays according to the co-insurance rate until the covered person has paid an amount equal to the co-insurance limit. Once the co-insurance limit has been met, the co-insurance percentage will automatically increase to 100% for any additional covered expenses incurred by that same person during the remainder of the calendar year. If a covered person has health coverage from any other source where coordination of benefits is allowable, including Medicare, Medicaid and TRICARE, the co-insurance limit does not apply. **Deductibles, co-pays, non-covered charges, charges reduced under the care management provisions, charges for mental health, chemical dependency, sleep studies, pain therapy/pain management, outpatient cardiac rehabilitation, outpatient skeletal adjustment, and charges in excess of Reasonable & Customary are not included in determining if a covered person has met the co-insurance limit for the year.**

	Preferred	Non-Preferred
Individual	$1,500	$2,400
Family	$4,500	$7,200

Amounts used to satisfy the non-preferred co-insurance limit will also be applied to the preferred co-insurance limit and vice versa.

Plan Maximum

The Plan Maximum is the maximum amount payable for Covered Medical Expenses by the Plan to or on behalf of the covered person **while covered by the Plan**. The Plan Maximum will apply even if your coverage is interrupted or if you or your dependent has been covered both as an employee and as a dependent. Once the total Plan payments for a covered person reach the Plan maximum, no more payments will be made by the Plan for that person.

Plan Maximum **$2,000,000**

PRIMARY CARE SERVICES

Your Plan encourages you to choose a primary care physician at the time you enroll in the Plan. **A primary care physician is a general internist, pediatrician, family physician or a gynecologist**. The benefits listed in this section apply only when provided in a primary care physician's office. Reasonable & Customary limitations may apply.

Services	Preferred	Non-Preferred (Reasonable & Customary Charges Apply)
1. Charges of your primary care physician for a visit to the office including surgical procedures	Payable at 100% after a $25 co-pay per visit	Payable at 60% after deductible

WELLNESS SERVICES

Services	Preferred	Non-Preferred (Reasonable & Customary Charges Apply)
1. Physical exams *Combined calendar year maximum $350*	Payable at 100% after a $25 co-pay per visit	Payable at 60% after deductible
2. Annual mammogram screening and gynecological exams (including pap tests and labs)	Payable at 100%	Payable at 100%, deductible waived
3. Prostate, PSA and rectal exams for men *Combined calendar year maximum $350*	Payable at 100% after a $25 co-pay per visit	Payable at 60% after deductible
4. Routine child care (up to age 6)	Payable at 100% after a $25 co-pay per visit	Payable at 60% after deductible
5. Contraceptives (See Definitions)	Payable at 100% after a $25 co-pay per visit	Payable at 60% after deductible
6. Abdominal aortic ultrasound *Limited to once between the age 65-75*	Payable at 100%	Payable at 100%, deductible waived
7. Colonoscopy *Limited to once every 10 years regardless of diagnosis*	Payable at 100%	Payable at 100%, deductible waived

OTHER COVERED SERVICES

Services	Preferred	Non-Preferred (Reasonable & Customary Charges Apply)
1. Charges of a specialist for a visit to the office including surgical procedures, not including labs or x-rays	Payable at 100% after a $45 co-pay per visit	Payable at 60% after deductible
2. Charges for laboratory and x-ray procedures in a specialist office	Payable at 80%	Payable at 60% after deductible

High Option Plan

Services	Preferred	Non-Preferred (Reasonable & Customary Charges Apply)
3. All other services rendered by a physician	Payable at 80%	Payable at 60% after deductible
4. Charges for chemotherapy/radiation	Payable at 80%	Payable at 60% after deductible
5. Charges for outpatient independent lab referred by physicians for illnesses not otherwise outlined in the Schedule of Benefits	Payable at 80%	Payable at 80%, deductible waived**
6. Charges of a hospital (facility) for outpatient treatment	Payable at 80%	Payable at 60% after deductible
7. Charges of a hospital (facility) for inpatient treatment	Payable at 80% after a per admission deductible of $300	Payable at 60% after deductible. An additional per admission deductible of $300 will also apply
8. Charges of a hospital for emergency room care	Payable at 80% after a $150 co-pay*	Payable at 60% after deductible and a $150 co-pay*
9. Charges of an emergency room physician	Payable at 80%	Payable at 80%, deductible waived**
10. Charges of an ambulatory surgery center	Payable at 80%	Payable at 60% after deductible
11. Charges of an urgent care center	Payable at 100% after a $25 co-pay	Payable at 100% after a $25 co-pay
12. Charges for allergy injections	Payable at 80%	Payable at 60% after deductible
13. Charges of a physician for maternity services	Payable at 80%	Payable at 60% after deductible
14. Charges of a facility for maternity services	Payable at 80% after a per admission deductible of $300	Payable at 60% after deductible. An additional per admission deductible of $300 will also apply
15. Charges for newborn nursery services	Payable at 80%	Payable at 60% after deductible
16. Charges for an MRI performed at "Open MRI"	Payable at 100%	Not Applicable
17. Charges performed at Spine Carolina	Payable at 90%	Not Applicable
18. Charges performed at "Mountain Neurological"	Payable at 90%	Not Applicable

High Option Plan

Services	Preferred	Non-Preferred (Reasonable & Customary Charges Apply)
19. Charges incurred which are considered out-of-area	Payable at 80%	Payable at 80%, deductible waived**
20. All other charges to include anesthesiologist, pathologist, radiologist	Payable at 80%	Payable at 80%, deductible waived**

*Co-pay waived if admitted.
**Preferred co-insurance limit also applies.

Pre-Certification Penalty

Hospital admissions require pre-certification. Pre-certification is the responsibility of the member. If pre-certification is not obtained, inpatient hospital benefits will be subject to a **$500 pre-certification penalty**. This penalty is separate from any other deductible of this Plan. The individual co-insurance payments for services where no pre-certification is obtained do not apply to the co-insurance limits. **(See the Care Management Services Section for a list of services requiring pre-certification).**

SPECIAL SERVICES

The following Benefit Limits apply to all physicians, facility and other related charges concerning these services.

Services	Preferred	Non-Preferred (Reasonable & Customary Charges Apply)
Mental Health (Inpatient)*** *Calendar year maximum 30 days*	Payable at 80% after a per admission deductible of $300	Not Covered
Mental Health (Outpatient) by an M.D. or Psychiatrist*** *Calendar year maximum 30 visits*	Payable at 100% after a $25 co-pay per visit	Payable at 50% after deductible
Mental Health (Outpatient) by any other provider*** *Calendar year maximum 30 visits*	Payable at 100% after a $25 co-pay per visit	Not Covered
Chemical Dependency (Inpatient)*** *Calendar year maximum 30 days* *Combined lifetime maximum $25,000* Inpatient, outpatient and Cornerstone of Recovery lifetime maximums are combined	Payable at 80% after a per admission deductible of $300	Not Covered
Chemical Dependency (Outpatient) by an M.D. or Psychiatrist*** *Calendar year maximum $2,500* *Combined lifetime maximum $25,000* Inpatient, outpatient and Cornerstone of Recovery lifetime maximums are combined	Payable at 100% after a $25 co-pay per visit	Payable at 50% after deductible
Chemical Dependency (Outpatient) by any other provider*** *Calendar year maximum $2,500* *Combined lifetime maximum $25,000* Inpatient, outpatient and Cornerstone of Recovery lifetime maximums are combined	Payable at 100% after a $25 co-pay per visit	Not Covered
Chemical Dependency at the Cornerstone of Recovery (Inpatient)*** *Combined lifetime maximum $25,000* Inpatient, outpatient and Cornerstone of Recovery lifetime maximums are combined	Payable at 100%	Not Applicable
Extended Care Facility, Skilled Nursing Facility, or Rehabilitation Facility *Combined calendar year maximum $20,000* *Skilled nursing calendar year maximum 100 days*	Payable at 80%	Payable at 60% after deductible

**Preferred co-insurance limit also applies.

****NOTE: These services require a referral from the Employee Assistance Network (EAN). Please contact them at 800-454-1477 for referrals. If a referral is not obtained prior to treatment, the following penalties will apply:* **Benefits will not be available if a referral is not obtained.**

SPECIAL SERVICES (CONTINUED)

The following Benefit Limits apply to all physicians, facility and other related charges concerning these services.

Services	Preferred	Non-Preferred (Reasonable & Customary Charges Apply)
Hospice Care	Payable at 80%	Payable at 60% after deductible
Home Health Care	Payable at 80%	Payable at 60% after deductible
Ambulance Service *Per Trip maximum $1,500*	Payable at 80%	Payable at 80%, deductible waived**
Durable Medical Equipment *Calendar year maximum $7,000*	Payable at 80%	Payable at 60% after deductible
Physical, Speech, and Occupational Therapy *Outpatient treatment period 18 weeks following first treatment for each illness, injury, or procedure*	Payable at 80%	Payable at 60% after deductible
Vertebral Manipulation/Outpatient Skeletal Adjustment *Calendar year maximum $1,000*	Payable at 50%	Payable at 50%, deductible waived
Sleep Studies *Calendar year maximum $2,500*	Payable at 80%	Payable at 60% after deductible
Pain Therapy / Pain Management *Calendar year maximum $2,500*	Payable at 80%	Payable at 60% after deductible
Cardiac Rehabilitation (Outpatient) *Outpatient treatment period 18 weeks following first treatment for each illness, injury, or procedure*	Payable at 80%	Payable at 60% after deductible
Infertility Diagnostic Testing	Payable at 80%	Payable at 60% after deductible
Prosthetics *Lifetime maximum $10,000*	Payable at 80%	Payable at 60% after deductible
Autism Spectrum Disorder**** *Lifetime maximum $10,000*	Payable at 80%	Payable at 60% after deductible
Ossatron Treatment for Plantar Fasciitis *Limited to one treatment based on recommendation of board certified Podiatrist*	Payable at 80%	Payable at 60% after deductible

**Preferred co-insurance limit also applies.

****A benefit for the treatment of Autism Spectrum Disorder should be used as a supplement to other benefits available through the Community. The benefits shall be provided to dependent children for a period not to exceed five (5) years after diagnosis. Further a lifetime maximum of $10,000 will be provided for the treatment of ASD to include speech therapy and other services recommended by the Huff Center at Mission.

PRESCRIPTION DRUG BENEFITS

The Plan includes a prescription drug benefit program, which utilizes an ID card and a network of participating pharmacies provided by Express Scripts, Inc. Participating pharmacies will accept the required co-payments and file your claim directly. **Claims for expenses incurred at non-participating pharmacies and claims filed manually (for prescriptions purchased without a drug card) will not be covered by the Plan for members who have a valid drug card.**

The Plan includes a mail order prescription drug benefit program administered by Express Scripts, Inc. Refer to the member packet for complete instructions on how to use this program.

Express Scripts also offers online tools to manage your prescription needs. To get detailed information via the web and learn about the Express Scripts programs and services, visit www.express-scripts.com.

The prescription co-payment rate varies depending on whether the prescription drug is classified as generic, formulary, non-formulary (brand name) or injectable, as follows:

Prescription Drug Card**	
Generic	Member pays $5 co-pay; *maximum 34 day supply*
Formulary Brand	Member pays $20 co-pay; *maximum 34 day supply*
Non-Formulary Brand	Member pays $45 co-pay; *maximum 34 day supply*
Injectables	Member pays $100 co-pay; *maximum 34 day supply*

**90-day supply available at retail

Calendar Year Maximum $25,000

City of Asheville Free Prescriptions (The following prescriptions will be available free of charge): Cephalexin, Clonidine, Doxycycline, TMP/SMZ Ds, HCTZ, Erythromycin, Lisinopril, Propranolol, Nirtrofuration, Trimox, Ibuprophen 600 mg, Amoxicillin, Amoxil, Ranitidine

Covered Benefits:

- Federal legend drugs
- State-restricted drugs
- Syringes and needles used only to inject insulin
- Insulin
- Oral and injectable contraceptives
- Injectables, subject to prior authorization
- Prior authorization is required on all prescriptions over $1,000

Exclusions:

- Appetite Suppressants
- Experimental or Investigational drugs, including compounded medications for non-FDA approved use
- Fertility medications
- Ostomy supplies (covered through the medical plan)
- Retin-A, which may be covered with a letter of medical necessity
- Over-the-counter medications
- Vitamins, except prenatal
- Rogaine
- Smoking cessation products
- Therapeutic devices or appliances, support garments, and other non-medical substances

CuraScript Injectable Drug Program

Curascript is a Specialty pharmacy owned by Express Scripts to deliver high cost injectable drugs as well as certain oral medications used in the treatment of certain chronic diseases. This program is offered to improve delivery and convenience if you or your covered dependents are using these medications.

This program eliminates the delay and prevents the inconvenience of traveling to the pharmacy. CuraScript will ship the drug and all the free supplies that are needed for the injections directly to your home or to the prescribing physician's office within twenty-four (24) to forty-eight (48) hours. In addition to the delivery convenience, CuraScript offers toll-free customer service available twenty-four (24) hours a day, three hundred sixty-five (365) days a year. Specially trained staff members offer support services for participants, their caregivers, and their physicians.

This program will work in the following manner:

The covered person will have the initial prescription filled at the pharmacy, which may require pre-authorization.
This will trigger CuraScript, which will generate a letter to the covered person and to the prescribing physician. After this initial contact, the covered person is automatically enrolled in a drug therapy management program, and all he or she has to do is call CuraScript customer service at 1-800-278-0980 to refill the specialty drug prescription.

This program entitles covered persons to receive the following at no extra charge:

- Access to nurses and pharmacists twenty-four (24) hours a day, seven (7) days a week for questions related to the drug and the illness the drug is treating
- Drug refill reminders if the covered person forgets to call for refills, and a convenient refill process
- Free delivery of medication and supplies to the covered person's home or other designated location

The disease list for which the Express Scripts CuraScript Injectable Drug Program has been designed includes but is not limited to:

Rheumatoid Arthritis
Multiple Sclerosis
Hemophilia
Hepatitis C
RSV (Respiratory Sentinel Virus)
Anemia (Chemotherapy related)

For a more complete list of diseases contact CuraScript at 1-800-278-0980.

STANDARD OPTION PLAN SCHEDULE OF BENEFITS

Medical Care Benefits

When injury or illness cause you or your dependents, while covered under this Plan, to incur Covered Medical Expenses, the Plan will determine benefits according to the provisions described in this Summary Plan Description and Master Plan Document. Benefits for each Covered Medical Expense will be calculated as follows:

1. The lesser of the actual, negotiated or Reasonable & Customary fee will be determined.
2. The amount will be reduced by any applicable deductible or co-pay and multiplied by the appropriate co-insurance level, resulting in the benefit payable.
3. The benefit payable will be subject to the maximums shown on the Schedule of Benefits.

Care Management Features

Your Plan includes one or more features to help control the cost of medical care coverage. Some features will affect the amount of benefits payable for covered expenses. (See the Care Management Services section for details).

Please note that the Plan is not directly involved in treatment, but only provides benefits for services that are covered under the terms of the Plan. Therefore, the Plan has no liability for the quality of care you may receive. You and your health care provider(s) are responsible for making all decisions regarding your health care and will control the course of treatment followed.

Pre-certification

Hospital admissions require pre-certification. If pre-certification is not obtained, a penalty will apply and benefits will be reduced and/or denied. (See the Care Management Services section for details).

Standard Organ Transplant Benefit

If a covered person does not meet all the requirements outlined in the Organ Transplant Program under Care Management Services, the co-insurance rate is 50% with a maximum benefit of $100,000 per transplant procedure.

Calendar Year Deductible

A covered person's deductible requirement will be met when Covered Medical Expenses incurred by that person, while covered during each calendar year, equal the deductible amount. You are responsible for paying the calendar year deductible. The Plan will not reimburse you for this expense. Co-pays, non-covered charges and separate hospital deductibles do not accumulate toward the calendar year deductible.

	Deductible
Individual	$1,200
Family	$3,600

Co-Insurance Rate

Co-Insurance rate is the percentage of Covered Medical Expenses payable by the Plan after the deductible requirement is met. The co-insurance rate for each type of service is listed in the Schedule of Benefits.

Co-Insurance Limit

Once the covered person has satisfied the required calendar year deductible requirement, the Plan will share the payment of covered charges according to the co-insurance rates listed in the Schedule of Benefits.

The Plan pays according to the co-insurance rate until the covered person has paid an amount equal to the co-insurance limit. Once the co-insurance limit has been met, the co-insurance percentage will automatically increase to 100% for any additional covered expenses incurred by that same person during the remainder of the calendar year. If a covered person has health coverage from any other source where coordination of benefits is allowable, including Medicare, Medicaid and TRICARE, the co-insurance limit does not apply. **Deductibles, co-pays, non-covered charges, charges reduced under the care management provisions, charges for mental health, chemical dependency, sleep studies, pain therapy/pain management, outpatient cardiac rehabilitation, outpatient skeletal adjustment, and charges in excess of Reasonable & Customary are not included in determining if a covered person has met the co-insurance limit for the year.**

	Co-Insurance limit
Individual	$2,200
Family	$6,600

Plan Maximum

The Plan Maximum is the maximum amount payable for Covered Medical Expenses by the Plan to or on behalf of the covered person **while covered by the Plan**. The Plan Maximum will apply even if your coverage is interrupted or if you or your dependent has been covered both as an employee and as a dependent. Once the total Plan payments for a covered person reach the Plan maximum, no more payments will be made by the Plan for that person.

Plan Maximum **$2,000,000**

PRIMARY CARE SERVICES

Your Plan encourages you to choose a primary care physician at the time you enroll in the Plan. **A primary care physician is a general internist, pediatrician, family physician or a gynecologist**. The benefits listed in this section apply only when provided in a primary care physician's office. Reasonable & Customary limitations may apply.

Services	Benefit
1. Charges of your primary care physician for a visit to the office	Payable at 80% after deductible
2. Charges of your primary care physician for office surgery	Payable at 80% after deductible

WELLNESS SERVICES

Services	Benefit
1. Physical exams *Combined calendar year maximum $350*	Payable at 100% after a $25 co-pay per visit
2. Annual mammogram screening and gynecological exams (including pap tests and labs)	Payable at 100%, deductible waived
3. Prostate, PSA and rectal exams for men *Combined calendar year maximum $350*	Payable at 100% after a $25 co-pay per visit
4. Routine child care (up to age 6)	Payable at 100% after a $25 co-pay per visit
5. Contraceptives (See Definitions)	Payable at 80% after deductible
6. Abdominal aortic ultrasound *Limited to once between the age 65-75*	Payable at 100%, deductible waived
7. Colonoscopy *Limited to once every 10 years regardless of diagnosis*	Payable at 100%, deductible waived

OTHER COVERED SERVICES

Services	Benefit
1. Charges of a specialist for a visit to the office including surgical procedures	Payable at 80% after deductible
2. All other services rendered by a physician	Payable at 80% after deductible
3. Charges for chemotherapy/radiation	Payable at 80% after deductible
4. Charges for outpatient independent lab referred by physicians for illnesses not otherwise outlined in the Schedule of Benefits	Payable at 80% after deductible

Services	Benefit
5. Charges of a hospital (facility) for outpatient treatment	Payable at 80% after deductible
6. Charges of a hospital (facility) for inpatient treatment	Payable at 80% after deductible
7. Charges of a hospital for emergency room care	Payable at 80% after deductible
8. Charges of an emergency room physician	Payable at 80% after deductible
9. Charges of an ambulatory surgery center	Payable at 80% after deductible
10. Charges of an urgent care center	Payable at 80% after deductible
11. Charges for allergy injections	Payable at 80% after deductible
12. Charges for maternity services	Payable at 80% after deductible
13. Charges for newborn nursery services	Payable at 80% after deductible
14. Charges for an MRI performed at "Open MRI"	Payable at 100% after deductible
15. Charges performed at Spine Carolina	Payable at 90% after deductible
16. Charges performed at "Mountain Neurological"	Payable at 90% after deductible
17. Charges incurred which are considered out-of-area	Payable at 80% after deductible
18. All other charges to include anesthesiologist, pathologist, radiologist	Payable at 80% after deductible

Pre-Certification Penalty

Hospital admissions require pre-certification. Pre-certification is the responsibility of the member. If pre-certification is not obtained, inpatient hospital benefits will be subject to a **$500 pre-certification penalty**. This penalty is separate from any other deductible of this Plan. The individual co-insurance payments for services where no pre-certification is obtained do not apply to the co-insurance limits. **(See the Care Management Services Section for a list of services requiring pre-certification).**

SPECIAL SERVICES

The following Benefit Limits apply to all physicians, facility and other related charges concerning these services.

Services	Benefit
Mental Health (Inpatient)*** *Calendar year maximum 30 days*	Payable at 80% after deductible
Mental Health (Outpatient)*** *Calendar year maximum 30 visits*	Payable at 80% after a $25 co-pay per visit
Chemical Dependency (Inpatient)*** *Calendar year maximum 30 days* *Combined lifetime maximum $25,000* Inpatient, outpatient and Cornerstone of Recovery lifetime maximums are combined	Payable at 80% after deductible
Chemical Dependency (Outpatient) *** *Calendar year maximum $2,500* *Combined lifetime maximum $25,000* Inpatient & outpatient lifetime maximums are combined	Payable at 80% after a $25 co-pay per visit
Chemical Dependency at the Cornerstone of Recovery (Inpatient)*** *Combined lifetime maximum $25,000* Inpatient, outpatient and Cornerstone of Recovery lifetime maximums are combined	Payable at 100%, deductible waived
Extended Care Facility, Skilled Nursing Facility, or Rehabilitation Facility *Combined calendar year maximum $20,000* *Skilled nursing calendar year maximum 100 days*	Payable at 80% after deductible
Ossatron Treatment for Plantar Fasciitis *Limited to one treatment based on recommendation of board certified Podiatrist*	Payable at 80% after deductible

**Preferred co-insurance limit also applies.

****NOTE: These services require a referral from the Employee Assistance Network (EAN). Please contact them at 800-454-1477 for referrals. If a referral is not obtained prior to treatment, the following penalties will apply:* **Benefits will not be available if a referral is not obtained.**

SPECIAL SERVICES (CONTINUED)

The following Benefit Limits apply to all physicians, facility and other related charges concerning these services.

Services	Benefit
Hospice Care	Payable at 80% after deductible
Home Health Care	Payable at 80% after deductible
Ambulance Service *Per Trip maximum $1,500*	Payable at 80% after deductible
Durable Medical Equipment *Calendar year maximum $7,000*	Payable at 80% after deductible
Physical, Speech, and Occupational Therapy *Outpatient treatment period 18 weeks following first treatment for each illness, injury, or procedure*	Payable at 80% after deductible
Vertebral Manipulation/Outpatient Skeletal Adjustment *Calendar year maximum $1,000*	Payable at 50% after deductible
Sleep Studies *Calendar year maximum $2,500*	Payable at 80% after deductible
Pain Therapy / Pain Management *Calendar year maximum $2,500*	Payable at 80% after deductible
Cardiac Rehabilitation (Outpatient) *Outpatient treatment period 18 weeks following first treatment for each illness, injury, or procedure*	Payable at 80% after deductible
Infertility Diagnostic Testing	Payable at 80% after deductible
Prosthetics *Lifetime maximum $10,000*	Payable at 80% after deductible
Autism Spectrum Disorder**** *Lifetime maximum $10,000*	Payable at 80% after deductible

**Preferred co-insurance limit also applies.

****A benefit for the treatment of Autism Spectrum Disorder should be used as a supplement to other benefits available through the Community. The benefits shall be provided to dependent children for a period not to exceed five (5) years after diagnosis. Further a lifetime maximum of $10,000 will be provided for the treatment of ASD to include speech therapy and other services recommended by the Huff Center at Mission.

PRESCRIPTION DRUG BENEFITS

The Plan includes a prescription drug benefit program, which utilizes an ID card and a network of participating pharmacies provided by Express Scripts, Inc. Participating pharmacies will accept the required co-payments and file your claim directly. **Claims for expenses incurred at non-participating pharmacies and claims filed manually (for prescriptions purchased without a drug card) will not be covered by the Plan for members who have a valid drug card.**

The Plan includes a mail order prescription drug benefit program administered by Express Scripts, Inc. Refer to the member packet for complete instructions on how to use this program.

Express Scripts also offers online tools to manage your prescription needs. To get detailed information via the web and learn about the Express Scripts programs and services, visit www.express-scripts.com.

The prescription co-payment rate varies depending on whether the prescription drug is classified as generic, formulary, non-formulary (brand name) or injectable, as follows:

Prescription Drug Card**	
Generic	Member pays $5 co-pay; *maximum 34 day supply*
Formulary Brand	Member pays $30 co-pay; *maximum 34 day supply*
Non-Formulary Brand	Member pays $50 co-pay; *maximum 34 day supply*
Injectables	Member pays $100 co-pay; *maximum 34 day supply*

**90-day supply available at retail

Calendar Year Maximum $25,000

City of Asheville Free Prescriptions (The following prescriptions will be available free of charge): Cephalexin, Clonidine, Doxycycline, TMP/SMZ Ds, HCTZ, Erythromycin, Lisinopril, Propranolol, Nirtrofuration, Trimox, Ibuprophen 600 mg, Amoxicillin, Amoxil, Ranitidine

Covered Benefits:

- Federal legend drugs
- State-restricted drugs
- Syringes and needles used only to inject insulin
- Insulin
- Oral and injectable contraceptives
- Injectables, subject to prior authorization
- Prior authorization is required on all prescriptions over $1,000

Exclusions:

- Appetite Suppressants
- Experimental or Investigational drugs, including compounded medications for non-FDA approved use
- Fertility medications
- Ostomy supplies (covered through the medical plan)
- Retin-A, which may be covered with a letter of medical necessity
- Over-the-counter medications
- Vitamins, except prenatal
- Rogaine
- Smoking cessation products
- Therapeutic devices or appliances, support garments, and other non-medical substances

CuraScript Injectable Drug Program

Curascript is a Specialty pharmacy owned by Express Scripts to deliver high cost injectable drugs as well as certain oral medications used in the treatment of certain chronic diseases. This program is offered to improve delivery and convenience if you or your covered dependents are using these medications.

This program eliminates the delay and prevents the inconvenience of traveling to the pharmacy. CuraScript will ship the drug and all the free supplies that are needed for the injections directly to your home or to the prescribing physician's office within twenty-four (24) to forty-eight (48) hours. In addition to the delivery convenience, CuraScript offers toll-free customer service available twenty-four (24) hours a day, three hundred sixty-five (365) days a year. Specially trained staff members offer support services for participants, their caregivers, and their physicians.

This program will work in the following manner:

The covered person will have the initial prescription filled at the pharmacy, which may require pre-authorization.
This will trigger CuraScript, which will generate a letter to the covered person and to the prescribing physician. After this initial contact, the covered person is automatically enrolled in a drug therapy management program, and all he or she has to do is call CuraScript customer service at 1-800-278-0980 to refill the specialty drug prescription.

This program entitles covered persons to receive the following at no extra charge:

- Access to nurses and pharmacists twenty-four (24) hours a day, seven (7) days a week for questions related to the drug and the illness the drug is treating
- Drug refill reminders if the covered person forgets to call for refills, and a convenient refill process
- Free delivery of medication and supplies to the covered person's home or other designated location

The disease list for which the Express Scripts CuraScript Injectable Drug Program has been designed includes but is not limited to:

Rheumatoid Arthritis
Multiple Sclerosis
Hemophilia
Hepatitis C
RSV (Respiratory Sentinel Virus)
Anemia (Chemotherapy related)

For a more complete list of diseases contact CuraScript at 1-800-278-0980.

COVERED MEDICAL EXPENSES

The following are considered expenses covered by the Plan provided they are incurred for such care, services and supplies as prescribed by an attending physician while the person is covered under this Plan:

1. Charges for **abortions**;
2. Charges for medically necessary professional **ambulance service** to or from a hospital, or charges by regularly scheduled airline, railroad or air ambulance to the nearest hospital qualified to give the required treatment;
3. Charges for an **ambulatory surgery center**;
4. Charges by a physician or professional anesthetist for **anesthesia** and its administration;
5. When an **assistant surgeon,** including a physician assistant, is required to render technical assistance during an operation, the eligible expense for such services shall be limited to 20% of the approved charge for the primary surgeon;
6. Charges for the initial purchase of an external **breast prosthesis** or post mastectomy bra (up to two per year), prescribed in connection with a mastectomy for which the person is receiving benefits under the Plan (however, replacement of the initial breast prosthesis is not covered);
7. Charges for the **circumcision** of a newborn;
8. Charges for **contraceptives**, including, but not limited to implantable contraceptives (Norplant), injectable contraceptives (Depo-Provera), transdermal contraceptives, diaphragms and IUD's, which require disbursement by a physician or a physician's prescription. The associated office visit is also covered *(See Definitions).*
9. Charges for **dental care** or treatment performed by a dentist or physician for the following:
   (a) Removal of malignant tumors and cysts;
   (b) Treatment of injury to sound natural teeth incurred as a result of an accident (other than an accident as a result of eating or chewing), including fixed bridgework and full or partial dentures and crowns, and rendered within twelve (12) months of the accident; and
   (c) Treatment for osteomyelitis as confirmed through pathology;
10. Charges for **diabetic supplies** to include insulin, limited diabetic supplies (syringes with or without needles), needles, alcohol swabs, blood glucose test strips, ketone test strips and tablets, lancets, and devices;
11. Medically necessary patient **education programs** for diabetic and ostomy care;
12. Charges for the initial purchase of a **hearing aid** if the hearing loss is a result of a surgical procedure performed while covered under this Plan. Further, Choclear Implants for infants up to age five with pre-approval may be covered.
13. Charges by a **home health** care agency;
14. Charges for **Hospice Care**;
15. **Hospital room and board** charges, up to a daily maximum of the prevailing semi-private room rate;
16. Charges for diagnostic testing of **infertility**. Charges for the treatment of infertility will not be covered;
17. Hospital charges for **intensive care**, cardiac care or other similar necessary accommodations;

18. **Maternity** Benefit: Benefits are payable for covered expenses incurred by the covered female employee or spouse due to pregnancy, childbirth and related conditions on the same basis as for illness (see Schedule of Benefits);
19. Charges for medical care or treatment for **mental and nervous disorders, alcoholism and chemical dependency**. Treatment for Attention Deficit Disorder (ADD and ADHD) will be considered under the mental and nervous disorders benefit;
20. **Miscellaneous hospital** charges (charges billed by the hospital other than room and board); other hospital services required for medical or surgical care or treatment;
21. Charges from a hospital for routine **newborn nursery care** and for the initial examination by a pediatrician at birth to determine the health of the infant;
22. Charges for medically necessary **nursing care** rendered by a registered nurse (R.N.) or, if none is available as certified by the attending physician, for services rendered by a Licensed Practical Nurse (L.P.N.), but only for nursing duties excluding custodial care and care by members of immediate family;
23. Benefits will be provided to an **organ transplant** recipient and the organ donor if the recipient is covered under this Plan;
24. Charges for **orthoptic** training (eye muscle exercises). Training by an optometrist does not have to be recommended by a physician. Training by an orthoptic technician must be prescribed by a physician;
25. Charges for **Ossatron Treatment** for the condition of plantar fasciitis. Treatment is limited to one per covered participant based on recommendations of a board certified Podiatrist, provided that the condition has persisted for six months or more with a history of unsuccessful conservative treatment. Conservative treatments that must have been attempted include, but are not limited to:
    (a) Prescription orthotics;
    (b) Physiotherapy modalities;
    (c) Use of medication such as anti-inflammatories; and
    (d) Maybe even cortisone injections.

    Additional treatments would require medical review and pre-authorization based on the circumstances of the case.
26. Charges for **pain therapy** including, but not limited to, pain clinics and/or labs, epidural steroid injections for the treatment of pain, and all testing and therapies related to the treatment of pain or pain management;
27. Charges for **physical therapy and occupational therapy**, when services are provided by licensed therapists;
28. Charges by a **physician** for medical care and treatment;
29. Charges for the following:

    (a) **Prescription drugs** (including insulin) that are (i) ordered for the patient in writing by a physician; and (ii) dispensed by a licensed pharmacist or a physician;

    (b) **Blood or blood plasma** and its administration, excluding any charges for blood or blood plasma which has been replaced by a donor;

    (c) **Medically** necessary supplies such as **casts, splints or surgical dressings, trusses, braces (except dental) or crutches**;

    (d) **The initial placement of artificial limbs or eyes;**

    (e) **Oxygen** and rental of equipment for its administration;

    (f) Rental of **durable medical equipment** at home, including but not limited to mechanical equipment for the treatment of respiratory paralysis; wheelchairs and hospital beds; however if the purchase price would be less than the rental cost for

long-term usage, the Plan will pay for the purchase of such equipment upon approval from the Plan Supervisor, but not for any repair;

30. Charges for **rehabilitative care**, but only for necessary medical care (as prescribed by a physician) which is rendered in a rehabilitation facility or hospital, to exclude custodial care or occupational training;
31. Charges for **routine physical examinations**;
32. Charges for treatment received in a **skilled nursing facility or extended care facility**;
33. Charges for **speech therapy** by a qualified speech therapist required because of an injury or illness other than psychosocial speech delay, behavior problems, attention disorder, conceptual disorder, or mental retardation. If therapy is required because of a congenital abnormality, the person must have had corrective surgery before therapy;
34. Charges for **sterilization** procedures, but not for the reversal of sterilization procedures;
35. Charges made by a physician for **surgical procedures** performed on an inpatient or outpatient basis. In the case of multiple surgical procedures performed through the same incision or separate incisions during the same operative session, the eligible expense for the surgeon will be the Reasonable & Customary charge or the contractual rate with the provider for the primary procedure, and 50% of the Reasonable & Customary charge or the contractual rate with the provider for the secondary procedure, and 50% of the Reasonable & Customary charge or the contractual rate with the provider for the third procedure;
36. Charges for outpatient **skeletal adjustment**, **adjunctive therapy**, **vertebral manipulation** and services for the care or treatment of dislocations or subluxations of the vertebrae;
37. Charges for **well baby care** services;
38. Charges for one **wig** per lifetime as a result of chemotherapy or radiation treatment;
39. Charges for diagnostic **x-ray or laboratory** examinations and their interpretation.

SPECIAL PROVISIONS

CHEMICAL DEPENDENCY
Treatment of substance abuse and chemical dependency or addiction must:

1. Be prescribed and supervised by a physician. It must have a follow-up therapy program directed by a physician on at least a monthly basis; or
2. Include meetings at least twice a month with approved organizations devoted to the treatment of substance abuse, such as Alcoholics Anonymous or Narcotics Anonymous.

Charges for treatment of substance abuse that is not approved treatment as defined above are not covered by this Plan.

CHEMICAL DEPENDENCY HOSPITAL CONFINEMENTS
If a person is confined as an inpatient in a hospital, the covered charges are as follows:

1. Treatment of the medical complications of substance abuse/chemical dependency;
2. Approved treatment of substance abuse/chemical dependency.

Pre-certification and Concurrent Review are required.

CHEMICAL DEPENDENCY TREATMENT FACILITY (NON-HOSPITAL)
Charges for room and board and other necessary services and supplies are covered up to the calendar year maximum and Plan maximum:

1. No room and board charges in excess of the semi-private room rate are covered.
2. The calendar year maximum for days of confinement will be reduced by any days of hospital confinement for mental health or chemical dependency that were previously covered.

Pre-certification and Concurrent Review are required.

Care that does not fit the definition of approved substance abuse treatment is not covered by this Plan. A covered treatment facility must be recognized by the Joint Commission on Accreditation of Hospitals and licensed by the state.

DENTAL CARE / ORTHODONTICS / ORAL SURGERY
Expenses for dental work and oral surgery are Covered Medical Expenses only if they are for the prompt repair of natural teeth, bone, or other body tissue needed as a result of an injury or malignancy. Medical attention following accidental injury must be reported within 72 hours of the incident to the primary care physician or to the appropriate provider to be a covered benefit. Treatment for cleft lip or cleft palate is covered as any other major medical expense.

EXTENDED CARE / REHABILITATION AND SKILLED NURSING FACILITIES
Charges for services and supplies from qualified extended care, rehabilitation and skilled nursing facilities are Covered Medical Expenses. The services must be furnished to a covered person while confined to convalesce from an illness or injury and must occur during a convalescent period. The convalescent period is defined as the first day a covered person is admitted to a facility, if that person:

1. Was previously admitted to a hospital for at least three (3) days of inpatient treatment for an illness or injury; and
2. Is admitted to the extended care or rehabilitation facility within thirty (30) days after discharge from the hospital; and
3. Is admitted to the extended care or rehabilitation facility for services needed to convalesce from the condition that caused the hospital stay.

These covered services include skilled nursing and physical restorative care. Covered extended care or rehabilitation facility expenses do not include treatment for drug addiction, chronic brain syndrome, alcoholism, senility, mental retardation or any other mental disorder.
Pre-certification and Concurrent Review are required.

HOME HEALTH CARE
Covered Home Health Care Expenses include:

1. Part-time or intermittent care by an R.N., or by an L.P.N. if an R.N. is not available;
2. Part-time or intermittent home health services including private duty nursing provided by a licensed nurse;
3. Physical, occupation and speech therapy; and
4. Medical supplies, medications or lab services ordered by a physician, which require nursing administration.

HOSPICE CARE
Hospice care with an approved Hospice Care Program, whether inpatient or outpatient, is a covered benefit. "Hospice Care Program" means a written plan of the care to be provided for the palliation and management of a person's terminal illness developed by or under the supervision of the attending physician. "Palliative care" is a course of treatment primarily directed at lessening or controlling pain while maximizing comfort. It does not attempt to cure the person's terminal illness.

HOSPITAL CARE
Intensive care charges in a hospital will be covered. Private room charges will not be covered unless certified as medically necessary by the attending physician and pre-certified by Primary PhysicianCare, Inc. Hospital observation stays are covered medical benefits as outlined under Hospital and Physician Benefits.
Pre-certification and Concurrent Review are required.

LASER SURGERY / NEW SURGICAL TECHNIQUES

The use of lasers in the surgical treatment of disease is a Covered Medical Expense only when the procedure has been proven superior to standard established surgical techniques. If laser is used when this criteria is not met in the pre-certification process, the procedure will be covered at the Reasonable & Customary charge for the standard surgical method of treatment. **Pre-certification and Concurrent Review may be required**.

MAMMOGRAPHY

Screening mammography is a special 2-view x-ray of the breast that is recommended every year for women age thirty-five (35) and older. Coverage of annual screening mammography at an earlier age may be provided if there is a strong family history of breast cancer or other medical conditions that would warrant earlier screening. Diagnostic Mammograms are more specialized procedures reserved for known problems. Usually five or more x-rays of each breast are performed during these procedures.

MASTECTOMY-BREAST RECONSTRUCTION

Any covered person who is receiving benefits under the Plan in connection with a mastectomy and elects breast reconstruction shall be eligible for coverage of the following, to be provided in a manner determined in consultation with the attending physician and the patient:

1. Reconstruction of the breast on which the mastectomy was performed;
2. Surgical reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and treatment of physical complications of mastectomy, including lymphedemas.

All of the benefits outlined above are subject to the Plan's deductibles, co-pay, co-insurance; Reasonable & Customary charge limitations and Care Management requirements. For more information, please contact the Plan Supervisor.

MATERNITY HOSPITALIZATIONS

Under federal law, the Plan may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a Cesarean section, or require that a provider obtain authorization from a plan for prescribing a length of stay not in excess of the above period. However, federal law does not prohibit the attending physician, after consultation with the mother, from discharging the mother or newborn before these periods have expired.

MENTAL HEALTH

Neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional illness or disorders of any kind are covered benefits. It does not include behavioral or learning disabilities. Prescription drugs used for these conditions are covered as any other prescription drugs, even if prescribed by a psychiatrist.

NEWBORN CARE
Routine newborn care includes hospital charges for room and board, services, supplies, and professional fees during the initial hospital confinement for in-hospital visits but only while the mother or infant is confined for delivery or post-delivery complications. Also included are charges for circumcision. (See Maternity Hospitalizations). (See Eligibility Requirements.)

ORGAN TRANSPLANTATION
See "Organ Transplant Program" in the **CARE MANAGEMENT SERVICES** section.

PHYSICAL, SPEECH AND OCCUPATIONAL THERAPY
Charges of a doctor or facility for physical, speech and occupational therapy that are covered expenses may be limited. The limitation applies for treatment received while the patient is not confined to the hospital as a bed patient (outpatient services). The limitation for treatment applies to the number of days that treatment may be received from the initial date of the accident, injury, or illness. A new period may begin 180 days after the last date of treatment for a given injury or illness. Speech therapy is not covered for psychosocial speech delay, behavior problems, attention disorder, conceptual disorder, or mental retardation.

ROOM AND BOARD CHARGES
Charges made by an institution for room and board and other necessary services and supplies must be regularly made at a daily or weekly rate. The semi-private rate is the charge that an institution applies to the beds in a semi-private room with two (2) or more beds. If a hospital has private rooms only, it will be paid the same as the semi-private room charge.

SKELETAL ADJUSTMENT
Treatment of the skeletal system performed by external manipulation including, but not limited to, vertebral manipulation and associated adjunctive therapy are covered benefits when medically necessary and when performed by physical therapists, chiropractors, osteopaths, and/or physicians.

SLEEP DISORDERS
Sleep studies and treatment include diagnosis, testing, surgery and all charges associated with sleeping disorders.

SPEECH THERAPY
See Physical, Speech and Occupational Therapy.

VERTEBRAL MANIPULATION
See Skeletal Adjustment.

WEEKEND HOSPITAL ADMISSION

If a covered person is admitted to a hospital as an inpatient on Friday, Saturday, or Sunday, no benefits will be paid for charges incurred on those days unless:

1. the confinement was for the birth of a child; or
2. surgery is scheduled within twenty-four (24) hours following admission to the hospital and was pre-certified; or
3. the confinement was a medical emergency.

If a hospital confinement is disallowed because of the above, the disallowed amount will **NOT** be counted toward the hospital deductible or co-insurance limits.

EXCLUSIONS

No benefits shall be payable under this Plan for any charges resulting from:

1. Charges for services performed more than twelve (**12) months prior** to receipt of the corresponding claim by the Plan Supervisor;
2. Illness or injury resulting from **acts of war**, insurrections, or atomic explosions;
3. Charges for **acupuncture, biofeedback** or **hypnosis**;
4. Charges for treatment of any injury or illness resulting from: a commission of or an attempt to commit an **assault** or **felony**; an injury resulting from a motor vehicle accident in which a covered person has a blood alcohol concentration equal to or in excess of the level established by the laws of the state in which the accident occurred for driving while impaired or where the covered person has pled guilty or was convicted for violating those laws pertaining to driving while impaired or intoxicated for that state. Charges resulting from these activities are excluded whether the covered person was sane, insane, or under the influence of drugs at the time of the activity. This exclusion does not apply if the injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
5. Charges for **attempted suicide or intentionally self-inflicted injury,** while sane or insane, or an injury resulting from an act of aggression or battery initiated by the covered person. This exclusion does not apply if the injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
6. Expenses incurred **before coverage begins** or **after coverage ends**;
7. Charges for **behavioral disorders** or **learning disabilities**;
8. Replacement **braces for the leg, arm, back, neck;** or **artificial arms** or **legs**, unless there is sufficient change in the covered person's physical condition to make the original device no longer functional;
9. **Charges in excess** of Reasonable & Customary (R&C) charges, where a contractual arrangement with the provider does not exist, including but not limited to physicians, hospitals, facilities, and providers of medical equipment and supplies;
10. **Cosmetic**, elective, plastic, reconstructive, or restorative surgery, except following illness or injury as specifically provided for in this Plan; including, but not limited to, rhinoplasty, abdominoplasty, lipectomy, liposuction, breast augmentation, and face lifts or complications arising from such services;
11. Charges for **custodial care**, or in connection with education, training and bed and board while confined to an institution which is primarily a school or other institution for training, a place of rest, a place for the aged, a nursing home, or a custodial care facility.
12. The **difference between the charge** for a service, procedure, or substance and the charge for a service, procedure, or substance that is known to be less expensive and would achieve the same or similar results with no additional medical risk;
13. Charges for professional services billed by a physician or nurse who is an **employee of a hospital or skilled nursing facility** and paid by the hospital or facility for services;
14. All **exercise programs** or exercise equipment for treatment of any condition, outside of prescribed rehabilitation program;
15. **Any Experimental or Investigational** treatment, procedure, facility, equipment, service, device, substance, or drug (see the Definitions section);

16. Any expenses for treatment, services, supplies, and facilities provided by or in a hospital owned or operated by any **government or agency thereof** where such care is provided at government expense under a plan or program established pursuant to the laws or regulations of any government or under a plan or program under which any government participates other than as an employer. The term "any government" includes the federal, veteran, state, provincial, municipal, or local government or, any political subdivision thereof, of the United States or of any other country. The Plan shall not exclude benefits for a covered person who received billable medical care at any of the above facilities.
17. Charges for the care and treatment of **hair loss**;
18. Charges for the examination, purchase or fitting of **hearing aids**, except the initial purchase of a hearing aid if the hearing loss is a result of a surgical procedure performed while covered under this Plan. Further, Choclear Implants for infants up to age five with pre-approval may be covered.
19. Any expense or charge for the treatment of **infertility** in men or women including:
    (a) reversals of surgical sterilization including reconstruction of vasectomy or reconstruction of tubal ligation; or
    (b) direct attempts to cause pregnancy by hormone therapy, artificial insemination, in vitro fertilization and embryo transfer; or
    (c) supervision of pregnancy by infertility specialists who do not practice obstetrics.
20. **Marital counseling, recreational, educational, or social therapy or training services** or any form of non-medical self care or self help training and any related diagnostic testing, except for medically necessary patient education programs for diabetic and ostomy care;
21. Services and supplies that are **not medically necessary** except for covered wellness benefits;
22. Conditions arising out of or as a result of **military service**;
23. Medical services or supplies for which **no charge** was made or for which no payment would be required if the covered individual was not covered under this Plan;
24. Charges for services and supplies that are **non-covered expenses**;
25. **Nutritional supplements**, special foods, or vitamins not prescribed by a physician;
26. Any treatment of **obesity** or **weight reduction,** whether surgical or medical;
27. Professional services performed by the covered person or a person who **ordinarily resides in the covered person's home** or is related to the covered person as a spouse, parent, child, brother, or sister, whether the relationship is by blood or exists in law;
28. Any artificial, mechanical or cross-species **organ or tissue transplant**;
29. Charges for treatment **outside of the United States**, unless you are a resident of the United States and you are traveling for business or pleasure and require emergency medical treatment;
30. **Personal comfort items** such as television, telephones, extra food trays, etc.;
31. Charges for **pre-existing conditions**;
32. Charges for **pregnancy** including delivery and complications **for covered dependents** other than the spouse of the covered employee;
33. Charges incurred as a **result of complications** arising from a service or procedure that is not a covered benefit;
34. Charges for **shock wave therapy** for orthopedic procedures, including but not limited to the treatment of Patellar Tendonitis, Shoulder Tendonitis and Medial Epicondylitis,

expect for Ossatron treatment for Plantar Fasciitis, which will be covered as noted under Special Services;

35. Charges for **telephone** consultations, missed appointments, or fees added for **filling out a claim form** or fees related to hospital pre-certification, concurrent review, utilization review, quality assurance, or case management;
36. Expenses incurred after **termination of coverage** under this Plan;
37. Routine examinations, periodic physical examinations, childhood checkups, examinations or services required or requested by any **third party**, including, but not limited to, employment, license, insurance, school, or recreational purposes. This includes hospital charges to the extent they are allocable to scholastic **education, vocational training,** or for confinements resulting from a local or state mandate (court ordered);
38. Charges for which a **third party is liable** (See "Third Party Liability" section) or charges for which the covered person is **not legally required to pay**;
39. Care, services, or treatment for **transsexualism, gender dysphoria or sexual reassignment** or change, including medications, implants, hormone therapy, surgery, medical or psychiatric treatment; also services or supplies related to sexual dysfunctions or inadequacies including penile prosthesis and all procedures and equipment developed for male impotency;
40. **Travel**, except for covered ambulance charges;
41. Charges incurred for any operation or **treatment for realignment of teeth or jaw or any other dental services not specifically provided for under Covered Medical Expenses**. Charges not covered include, but are not limited to: **oral care** or supplies for treatment of nerves connected to teeth, charges for treatment of atrophy of the lower jaw, occlusion, maxillofacial surgery, Temporomandibular Joint dysfunction and retrognathia. The above charges are excluded unless otherwise provided in the Schedule of Benefits, or provided under DENTAL CARE/ORTHODONTICS/ORAL SURGERY (See the Special Provisions section). This exclusion shall not be construed to deny otherwise eligible expenses for the treatment of the teeth or jaws when such treatment is necessitated by traumatic injury that occurs within one year prior to the treatment;
42. The following care, **treatment or supplies for the feet**: orthopedic shoes, orthopedic prescription devices to be attached to or placed in shoes, treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions except open cutting operations, and treatment of corns, calluses or toenails unless needed in treatment of a metabolic or peripheral-vascular disease. Orthopedic shoes and prescription devices will be covered if medically necessary because one leg is shorter than the other or if related to plantar fasciitis;
43. **Vision care** including but not limited to eyeglasses, contact lenses, refractions, radial keratotomy, LASIK surgery and any surgery which involves corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error, unless covered by a vision benefit in the Plan The vision benefit in the plan is only available under the High Option Plan;
44. **Weekend admissions** as described in the DEFINITIONS section;
45. Charges resulting from illness or injury covered by the **Worker's Compensation Act** or similar law; and charges resulting from an accidental injury or illness arising out of or in the course of employment for wages or profit (past or present).

PRE-EXISTING CONDITIONS

A Pre-Existing Condition is a condition for which medical advice, diagnosis, care or treatment was recommended or received within six (6) months preceding the person's enrollment date for this Plan. Genetic information is not a condition. Treatment includes receiving services and supplies, consultations, diagnostic tests, or prescribed medications. In order for a condition to be determined as pre-existing, the medical advice, diagnosis, care or treatment must have been recommended by, or received from, a physician.

Covered charges incurred for Pre-Existing Conditions are not payable unless incurred twelve (12) consecutive months after the person's enrollment date in this Plan, or eighteen (18) months if the person is a late enrollee. The length of the Pre-Existing Condition exclusion may be reduced or eliminated if the person has proof of creditable coverage from another health plan. "Creditable coverage" is a period of coverage under a prior health plan without a break in coverage of sixty-three (63) days or more.

1. An eligible person may request a certificate of creditable coverage from his or her prior plan. The Employer will assist any eligible person in obtaining a certificate of creditable coverage from the prior plan.
2. If, after a certificate of creditable coverage has been obtained, there is still a Pre-Existing Condition exclusion imposed on an individual, that individual will be so notified.

Your enrollment date is the first day of coverage by this Plan, or, if the Plan has a waiting period, the first day of the waiting period. If you do not immediately enroll, your enrollment date will be considered the first day of coverage under the Plan. (See Timely or Late Enrollee.)

The Pre-Existing Condition limitation does not apply to:

- pregnancy
- a newborn child who is enrolled in the Plan within thirty-one (31) days of birth, or
- a child who is legally adopted by you or placed for adoption with you before attaining the age of eighteen (18), as long as the child is enrolled in the Plan within thirty-one (31) days of the date of the adoption or placement for adoption. The Pre-Existing Condition exclusion may apply to coverage before the date of the adoption or placement for adoption.
- a child who is an alternate recipient under a Qualified Medical Child Support order (QMCSO)

The waiver of a Pre-Existing Condition exclusion for newborns and children adopted or placed for adoption does not apply to an employee who has had a break in creditable coverage of sixty- three (63) or more days.

DEFINITIONS

The following terms will help you understand your Plan better. The inclusion of any phrase or word below is not intended to imply that coverage for the service or supply is provided under the Plan.

ACCIDENTAL INJURY
Accidental injury is an immediate, unforeseen event caused by an external trauma to the body of a covered person, which is unrelated either directly or indirectly to all other causes and which requires treatment by a physician.

ALCOHOLISM/CHEMICAL DEPENDENCY
Alcoholism/chemical dependency is the use or abuse of alcohol or other drugs, which produces a state of psychological and/or physical dependency in a manner that impairs personal, social or occupational functioning. This may include a pattern of tolerance and withdrawal.

AMBULATORY SURGICAL CENTER
An ambulatory surgical center is any licensed public or private establishment with an organized medical staff of physicians with permanent facilities that (i) is equipped and operated primarily for the purpose of performing surgical procedures; (ii) provides continuous service of physicians and registered professional nurses whenever a patient is in the facility, and (iii) which does not provide services or other accommodations for patients to stay overnight. Facilities must be approved by the Joint Commission on Accreditation of Hospitals.

BENEFIT MAXIMUM
Benefit maximum is the maximum expenditure for a particular benefit that will be payable for the entire period that the person is covered by the Plan. When a covered person reaches this level of Plan expenditure, no other payments will be made for that benefit. Once reached, the limitation will apply for as long as the person is covered by the Plan. Benefits paid toward a benefit maximum also accrue toward the Plan maximum.

CALENDAR YEAR MAXIMUM
Calendar year maximum is the maximum expenditure for a particular benefit that will be payable over a calendar year. When that expenditure level is reached, payments for that benefit terminate until the next calendar year begins. Benefits paid for calendar year maximums accrue toward the benefit and Plan maximums.

CLAIM
A claim is any request for a Plan benefit, made by a claimant or by a representative of a claimant that complies with the Plan's procedures for making benefit claims.

COBRA
"COBRA" stands for the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, and any applicable regulations.

CO-INSURANCE RATE
Co-insurance rate is the rate or percentage that the Plan pays for Covered Medical Expenses after the calendar year deductible and/or co-pay has been met, subject to any applicable benefit maximums and the Plan maximum.

CO-INSURANCE LIMIT
Co-insurance limit is the maximum amount that a covered person must pay during the calendar year before the co-insurance rate is increased to 100% for any additional Covered Medical Expenses that do not apply to the co-insurance limit (See Schedule of Benefits) which are incurred by that person during the remainder of the calendar year. The Plan has individual as well as family annual co-insurance limits.

CONCURRENT CARE CLAIM
There are two types of Concurrent Care Claims:

- A claim to extend coverage for a course of treatment beyond a previously approved period of time or number of treatments, and
- A claim regarding reduction or termination of coverage by the Plan before the end of a previously approved period of time or number of treatments.

CONTRACEPTIVES
Benefits are available for the following items, which require disbursement by a physician or a physician's prescription: injectable contraceptives; contraceptive devices including, but not limited to, diaphragms and IUDs; transdermal contraceptives; and implantable contraceptives including, but not limited to, Norplant. Oral contraceptives are covered under the Prescription Drug Benefit. Over the counter contraceptives are not covered.

CO-PAY OR CO-PAYMENT
Co-pay is the amount that the covered person is required to pay before Plan payment begins and which is separate from the individual deductible. The co-pay does not accrue towards the deductible or co-insurance limits. Co-payments are required for certain covered services even if the deductible and/or co-insurance limit has been reached.

COSMETIC SURGERY
Cosmetic surgery is a procedure performed primarily to preserve or improve appearance rather than to restore the anatomy and/or functions of the body that are lost or impaired due to an illness or injury.

COVERED MEDICAL EXPENSES
Covered medical expenses are expenses for medical care provided to an individual while covered under the Plan and for which coverage is available under the Plan (see the Schedule of Benefits and Covered Medical Expenses sections for listings). Benefits for Covered Medical Expenses are subject to all the terms, conditions and limitations of the Plan.

CUSTODIAL CARE
Custodial care refers to services and supplies, including room and board and other institutional services, which are provided to an individual, whether disabled or not, primarily to assist him in the activities of daily living. These services and supplies are classified as custodial care regardless of the practitioner or provider who prescribes, performs or recommends the services.

DEDUCTIBLE
Deductible is the "out-of-pocket" amount, before co-insurance, that a covered person must pay for certain Covered Medical Expenses. This deductible is separate from co-payments. Individual as well as family deductibles apply under this Plan.

> **Family Deductible** – The family deductible is satisfied when the sum of all deductible payments for covered family members meets the calendar year family deductible amount. Any covered charges incurred by any covered family member after the family deductible is satisfied will be paid at the co-insurance rate up to applicable plan limits for the remainder of the calendar year.

DENTAL SERVICES
Dental services are procedures involving the teeth, gums or supporting structures.

DURABLE MEDICAL EQUIPMENT
Durable medical equipment is a device that is able to withstand repeated use, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of an illness or injury, and is prescribed by a physician and appropriate for use in the home.

EFFECTIVE DATE
Effective date is the date on which an employee or dependent is covered by the Plan.

ELIGIBILITY DATE
Eligibility date is the date on which an employee or dependent becomes eligible to participate in the Plan.

EMERGENCY CARE
Emergency care is care or services received due to a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson possessing an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to place the health of the individual in serious jeopardy, cause serious impairment to bodily functions, or cause serious dysfunction of any bodily organ or part.

EMERGENCY ROOM PHYSICIANS
Emergency room physicians are physicians who provide emergency services located in hospitals or in minor emergency centers. Care by emergency room physicians is not given on an on-going basis, and emergency room physicians do not admit and follow patients when hospitalized. For the purposes of this Plan, emergency room physicians are not considered to be primary care physicians.

EMPLOYEE
Employee is any person who is employed by the Employer, excluding any leased employees, independent contractors, or contract employees. Individuals classified by the Employer as leased employees, independent contractors or contract employees shall be excluded from Plan participation even if they are subsequently determined to be common law employees by any court or government agency.

EMPLOYER
Employer is **City of Asheville** and any affiliates that participate in the Plan for the benefit of eligible employees.

ENROLLMENT DATE
Enrollment date is the first day of coverage or, if the Plan has a waiting period, the first day of the waiting period. The enrollment date for a late enrollee or any person who enrolls during a special enrollment period is considered to be the first date of coverage under this Plan.

EXPERIMENTAL OR INVESTIGATIONAL
A treatment (other than covered off-label drug use) will be considered to be experimental or investigational if:

1. The treatment is governed by the Food and Drug Administration (FDA) and the FDA has not approved the treatment for the particular condition at the time the treatment is provided; or
2. The treatment is the subject of on-going Phase I, II, or III clinical trials as defined by the National Institute of Health, National Cancer Institute or FDA; or
3. There is documentation in published U.S. peer-reviewed medical literature stating that further research, studies, or clinical trials are necessary in order to determine the safety, toxicity or efficacy of the treatment.

FACILITY
A Facility is a healthcare institution which meets all applicable state or local licensure requirements, and which includes, but is not limited to the following: hospitals, skilled nursing facilities, intermediate care facilities, ambulatory surgical centers, free standing dialysis facilities or lithotriptor centers.

FORMULARY DRUGS
Formulary drugs are specified alternative prescription drugs for specific brand name drugs. Formulary drugs have been reviewed for safety, quality, effectiveness, and cost. A list of the Plan's formulary drugs is included in the member information packet. The formulary drug list is periodically reviewed and modified by a panel of physicians and pharmacists.

FULL-TIME STUDENT
A full-time student is a student enrolled for a number of hours, credits or courses considered full-time by the accredited educational institution where he or she is in attendance.

GENERIC DRUGS
"Generic drugs" is a term used for prescription drugs identified by their chemical name. When the patent has expired on a brand name drug, the FDA permits manufacturers other than the original developer to create a bioequivalent of the brand name drug and make it available to the public. Generally, more than one manufacturer will create the generic version, although in many cases the same pharmaceutical firm that produces the brand name drug also makes the generic version. This prompts competitive pricing of the generic version and usually results in a less expensive drug.

HOME HEALTH CARE
Home Health care is a formal program of care and treatment that is performed in the home of a person, is prescribed by a physician, and is prescribed in lieu of treatment in a hospital or skilled nursing facility or results in a shorter hospital or skilled nursing facility stay. The home health care program must be organized, administered, and supervised by a hospital or qualified licensed personnel under the medical direction of a physician.

HOSPICE
Hospice is an agency that provides counseling and medical services and may provide room and board for a terminally ill individual. Hospice services must meet all of the following requirements:

1. It is licensed and has obtained any required state or governmental Certificate of Need approval;
2. It is under the direct supervision of a physician, has a nurse coordinator who is a registered nurse (R.N.) and provides service twenty-four (24) hours a day, seven (7) days a week;
3. It is an agency that has as its primary purpose the provision of hospice services;
4. It has a full-time administrator and maintains written records of services provided to the patient.

HOSPITAL
An institution is considered to be a hospital if it fully meets each of the following requirements:

1. It maintains on the premises, on an inpatient basis, diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick and injured persons, by or under the supervision of a staff of duly qualified physicians; and
2. It continually provides on the premises twenty-four (24) hours a day registered nurse (R.N.) services; and
3. It is recognized as a hospital by the Joint Commission on Accreditation of Hospitals; and
4. It charges fees for its services.

The term "hospital" will not include, nor will the term "covered charges" include charges incurred in connection with confinement in any institution or part thereof used principally as a rest or nursing facility or a facility for custodial care. Facilities for the treatment of mental disorders, drug and/or alcohol addiction must be licensed by the State Board of Health and approved by the Joint Commission on Accreditation of Hospitals.

HOSPITAL PER ADMISSION DEDUCTIBLE
The hospital per admission deductible applies to each hospital admission. It is separate from the individual deductible, family deductible, physician co-payment, and co-insurance limit.

HOSPITAL PER OCCURRENCE DEDUCTIBLE
The hospital per occurrence deductible applies to each hospital and/or outpatient facility encounter. It is separate from the individual deductible, family deductible, physician co-payment, and co-insurance limit.

ILLNESS
An Illness is a mental or physical disease or infirmity, including pregnancy or pregnancy-related conditions.

INJURY
An Injury is the accidental bodily harm to a covered employee or covered dependent.

MEDICALLY NECESSARY
Care and treatment is "medically necessary" if the Plan Administrator or its delegate determines that the care and treatment meets all of the following conditions:

1. It is recommended and provided by a licensed physician, dentist or other medical practitioner who is practicing within the scope of his or her licenses: and
2. It is appropriate for the symptoms and is consistent with the diagnosis, if any. "Appropriate" means that the type, level and length of services and setting are needed to provide safe and adequate care and treatment; and
3. It is generally accepted as the standard of medical practice and care for the diagnosis and treatment of the particular condition; and
4. It is specifically allowed by the licensing statutes which apply to the provider who renders the service; and
5. It is ordered and documented in a timely fashion in the covered person's medical record; and
6. If an inpatient procedure, it could not have been adequately performed in an outpatient facility.

The fact that a physician may prescribe, recommend, approve or view a service or supply, as medically necessary does not make that service or supply medically necessary under the Plan. The Plan Administrator has sole and complete discretionary authority to determine whether the service or supply is medically necessary as defined under the Plan and may seek assistance or guidance for its determination from the Medical Department of Primary PhysicianCare, Inc.

MEMBER
Member is an employee or dependent that satisfies the requirements outlined in the Eligibility section and is enrolled in the Plan.

MENTAL AND NERVOUS DISORDERS
A mental or nervous disorder is a disease or condition, except those related to the abuse of or dependency on alcohol or other chemical substances, that is classified as a mental or nervous disorder in the current edition of Internal Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), U.S. Department of Health and Human Services Publication No. (PHS) 89-1260, or in any subsequent revision of the International Classification of Diseases published by the U.S. Government Printing Office.

NON-PREFERRED PROVIDER
As outlined in the Schedule of Benefits, this Plan may reimburse differently based on whether the hospital/facility, physician or other medical service provider is contracted as a participating provider with the Plan or through a preferred provider network supplementary to the Plan. A "non-preferred provider" is one who has not elected to participate in the Plan or through a preferred provider network supplementary to the Plan. All charges by a non-preferred provider are subject to the Plan's definition of Reasonable & Customary.

OUT-OF-AREA BENEFITS
Out-of-area benefits apply to members who reside in a location that does not offer access to a sufficient number or specialty of preferred providers. The Plan Administrator determines which members are covered through the out-of-area provision. Out-of-area benefits also apply to emergency care.

OUTPATIENT/REFERENCE DIAGNOSTIC LAB CHARGES
Charges incurred from independent freestanding reference labs and/or charges incurred on an outpatient basis from a hospital and/or facility.

PAIN THERAPY / PAIN MANAGEMENT
Pain therapy/pain management treatment includes but is not limited to epidural steroid injections, nerve blocks, pain center (facility) fees, and all other related professional services. This does not include services received as a result of malignancy.

PARTICIPATING PHARMACY
Participating pharmacy is any pharmacy licensed to dispense prescription drugs that is included as a participant in the program offering pre-paid benefits to eligible Plan participants.

PHYSICIAN
The term physician is a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.) who is legally qualified and licensed without limitation to practice medicine, surgery or obstetrics at the time and place service is rendered. For services covered by this Plan and for no other purpose, doctors of dental surgery, doctors of dental medicine, doctors of podiatry or surgical chiropody, chiropractors, optometrists, licensed psychologists, physical therapists, occupational therapists, speech therapists, physician assistants, nurse practitioners, licensed medical social workers, and midwives are deemed to be physicians when acting within the scope of their state licenses. Physician assistants, nurse practitioners, and midwives must practice under the direct supervision of a physician (M.D. or D.O.). Physical, occupational and speech therapy must be prescribed by a physician (M.D. or D.O.). PhDs in psychology are also considered covered providers.

PLAN ADMINISTRATOR
Plan Administrator is the Plan Sponsor or the person or committee appointed by the Plan Sponsor to carry out the administration and management of the Plan. The Plan Administrator has sole and complete discretionary authority to interpret the Plan, including those provisions relating to eligibility and benefits due under the Plan, and to make all determinations, including factual determinations, arising under the Plan.

PLAN MAXIMUM
The Plan Maximum is the maximum amount payable for Covered Medical Expenses by the Plan to or on behalf of the covered person while covered by the Plan. The Plan Maximum will apply even if your coverage is interrupted or if the person has been covered both as an employee and as a dependent. Once the total Plan payments for a covered person reach the Plan Maximum, no more payments will be made by the Plan for that person.

PLAN PARTICIPANT
Plan participant is an employee of the Employer who is covered under the Plan.

PLAN SUPERVISOR
Plan Supervisor is the person or firm employed by the Plan Sponsor to provide administrative services to the Plan including the processing and payment of claims.

POST -SERVICE CLAIM
Post-Service Claims are any claims filed for payment of benefits after medical care has been received.

PRE-EXISTING CONDITION
A Pre-Existing Condition is a condition for which medical advice; diagnosis, care or treatment was recommended or received within six (6) months of the person's enrollment date under this Plan. Genetic information is not a condition. Treatment includes receiving services and supplies, consultations, diagnostic tests or prescribed medications. In order to be taken into account, the medical advice, diagnosis, care or treatment must have been recommended by or received from a physician or other health care provider.

PRE-SERVICE CLAIM
Pre-Service Claim is a claim for a benefit under this Plan when the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. For more information, see the Care Management Services section.

PREFERRED PROVIDERS
A preferred provider is one who has elected to participate in the Plan or through a preferred provider network supplementary to the Plan. A directory of preferred providers is available from the Plan Administrator. This Plan may reimburse differently based on whether the hospital/facility, physician, or other medical service provider participates directly in the Plan or through a preferred provider network supplementary to the Plan.

PRIMARY CARE PHYSICIAN (PCP)
A PCP is a physician specializing in internal medicine, general practice, family practice, pediatrics, and/or obstetrics or gynecology chosen by the covered person to manage the continuity of his or her medical care. Certified Physician's Assistants (PAC's) and Certified Nurse Practitioners (CNP's) supervised by the primary care physician may also be considered PCP's under the Plan as long as they practice in the same location as the PCP.

REASONABLE & CUSTOMARY (R&C) CHARGES
A Reasonable & Customary charge is the usual charge made by a physician or other provider of services or supplies and will not exceed the general level of charges made by other physicians or providers rendering or furnishing the same services or supplies for the illness or injury being treated within the area in which the charge is incurred. The term "area" as it applies to any particular service or supply means a county or larger geographic area as necessary to obtain a representative cross-section of levels of charges. Charges in excess of Reasonable & Customary Charges are not covered expenses under this Plan.

RETIREMENT
Retirement begins on the first day on which retirement benefits become effective under:

1. Any plan of a federal, state, county, municipal or association retirement system for which the employee is eligible as a result of employment with the Employer; or
2. Any plan which the Employer sponsors; or
3. Any plan to which the Employer makes contributions or has made contributions; or
4. The United States Social Security Act or any similar plan or act. If the employee is in active employment and is receiving disability benefits under the United States Social Security Act or any similar plan or act, the employee will not be considered retired.

SICKNESS
An illness or disease of a covered employee or covered dependent including congenital defects or birth abnormalities.

SKELETAL ADJUSTMENT
Skeletal Adjustment is the treatment of the skeletal system performed by external manipulation including, but not limited to, vertebral manipulation and associated adjunctive therapy.

SLEEP DISORDER
Sleep Disorders include but are not limited to sleep apnea, snoring, and narcolepsy.

TEMPOROMANDIBULAR JOINT SYNDROME (TMJ)
TMJ is an abnormal condition characterized by facial pain and by mandibular dysfunction usually caused by a defective or dislocated temporomandibular joint.

TRANSPLANT
See Organ Transplant Program under the Care Management Services section.

URGENT CARE CENTERS
An urgent care center is a public or private establishment that is equipped and operated primarily for the purpose of providing emergency treatment or performing surgical procedures and which does not provide services or other accommodations for patients to stay overnight. An urgent care center must be staffed by physicians and registered nurses.

URGENT CARE CLAIM
An Urgent Care Claim is any claim for medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, in the opinion of the attending or consulting physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim. A physician with knowledge of the claimant's medical condition may determine if a claim is one involving urgent care. If there is no such physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson possessing an average knowledge of health and medicine may make the determination.

WEEKEND ADMISSIONS
Weekend admission is any admission to a hospital made between Friday at 5:00 p.m. and Sunday at midnight.

CARE MANAGEMENT SERVICES

The Plan features certain care management services designed to help ensure that all covered persons receive necessary and appropriate health care while avoiding unnecessary expenses when a hospital confinement, a surgical procedure or certain other care is proposed. It is important that covered persons use the program and follow all necessary steps as required. Failure to comply with these requirements will result in a penalty that can cause benefits to be reduced or denied.

PRE-CERTIFICATION PROCESS

In order to receive full benefits for hospital admissions, outpatient surgery and other services listed below, the covered person must obtain pre-certification prior to receiving the services or treatment.

Services To Be Pre-Certified

Pre-certification is required for: emergency hospital admissions, non-emergency hospital admissions (including observation), inpatient care in chemical dependency centers, inpatient care in mental health treatment centers, inpatient care in extended care facilities, inpatient care in skilled nursing facilities, inpatient rehabilitation services.

FOR PRE-CERTIFICATION CALL:
1-800-472-5001
8:30am—5:00pm EST
Monday through Friday

Hospital Admissions

For Emergency Admission: The covered person or an authorized representative of the family or the admitting office must call within forty-eight (48) hours or by the end of the first business day after admission.

For Non-Emergency Admission: The covered person or an authorized representative of the family or the admitting office must have the hospital/facility days certified by calling Primary PhysicianCare's Medical Department when planning a future admission for the covered person. This should be done at least five (5) days before the scheduled date of admission.

Pre-certification is the ultimate responsibility of the covered person. If the member is unsure whether pre-certification has been made, he or she should call to verify.

Pre-Certification Penalty

See Schedule of Benefits.

UTILIZATION REVIEW

When a hospital admission or other admission requiring pre-certification is recommended, the Medical Department of Primary PhysicanCare must be contacted for utilization review.

Information Needed for Review. The following information will be needed for a review:

1. Employee name and member number;
2. Employer's name;
3. Patient's name and date of birth;
4. Name, address, and phone number of admitting/attending physician;
5. Date of hospital/facility admission; and
6. Hospital/facility name, address, and phone number.

Physician Contact. Primary PhysicianCare's Medical Department will contact the attending physician as part of the pre-certification process to:

1. Discuss the admitting diagnosis and the procedure(s) to be performed;
2. Determine if an outpatient option applies and if the procedure(s) can/should be performed on an outpatient basis;
3. Document any change in diagnosis or treatment; and
4. Agree upon the number of days in the hospital/facility for the specific procedure(s).

Hospital/Facility Contact. During the covered person's inpatient stay, Primary PhysicianCare's Medical Department will contact the hospital/facility as part of the pre-certification process in order to determine that:

1. The admission takes place upon the determined date and the prescribed care is being administered;
2. The patient is actually receiving the treatment outlined by the physician; and
3. The patient is released from the hospital/facility when inpatient care is no longer needed.

Inpatient Extension Process. If, in the opinion of the patient's physician, it becomes necessary to extend the stay, then the physician or the hospital/facility may request an extension of the certification by calling Primary PhysicianCare's Medical Department. This must be done no later than on the last day that has already been certified.

Treatment Disagreements. When there is a disagreement between the Primary PhysicianCare's medical review coordinator and the attending physician as to the length of stay, course of treatment, or any other medical need, the physician may proceed as he sees fit, although covered benefits could be affected. The attending physician always has control of all treatment issues once the patient is admitted to the hospital/facility. The role of the Plan Administrator and of Primary PhysicianCare's Medical Department in the utilization management process pertains solely to coverage under the terms of this Plan.

Pre-Admission Certification is not a guarantee of either payment of benefits or the amount of benefits. Eligibility for and payment of benefits are subject to the terms of this Plan. If pre-certification is not obtained due to special circumstances and the member notifies the Plan Supervisor promptly of those circumstances, the applicable benefit reductions and penalties may be waived. Waivers will be applied in a consistent, nondiscriminatory manner to all similarly situated persons.

CASE MANAGEMENT

If a covered person suffers an injury or illness for which health care needs are likely to be very complex and/or costs extremely high, the case may be referred for case management by Primary PhysicianCare**.** After reviewing the case, the case manager may decide that an alternative plan of treatment is available. If an alternative plan of treatment is approved, benefits other than those described in this Summary Plan Description as Covered Medical Expenses may be payable if recommended by the case manager. Recommendations are made only on a prospective basis and only if the treatment is agreed to by the patient, the attending physician, and case management on behalf of the Plan. The Plan reserves the right to pay preferred benefits to any provider willing to enter into a negotiated arrangement through the case management program.

ORGAN/TISSUE TRANSPLANT PROGRAM

The Plan covers certain organ transplant procedures when a covered person is the recipient of the organ. The co-insurance limit will not apply for the transplant procedure unless (a) the procedure is arranged through case management and (b) the procedure is performed at an approved facility or hospital.

1. Eligible charges incurred by the covered person will be paid for the following donor expenses directly related to the procurement of a living or cadaver human organ for any covered transplant procedure:
   (a) testing to identify a suitable donor,
   (b) transportation of a donor to and from the site of the transplant procedure,
   (c) life support of a donor to and from the site of the transplant procedure,
   (d) hospital, medical and surgical charges related to the removal of the donated organ(s), and
   (e) storage and transportation of donated organ(s).

2. Charges incurred for organ transplant surgery will be paid for the following organ transplant categories to allow for reasonable and medically necessary care and treatment. All other organ transplants not specifically mentioned here will be excluded and no benefits will be paid for any charges associated with them. **Covered organ transplant categories** are:
   (a) bone marrow
   (b) heart
   (c) lung
   (d) kidney
   (e) pancreas
   (f) liver
   (g) peripheral stem cell

3. Covered Medical Expenses will include:
   (a) use of temporary life-support equipment, pending the acquisition of "matched" human organs,
   (b) multiple transplants during one operative session,
   (c) replacement(s) or subsequent transplant(s),
   (d) follow-up expenses for covered services (including immuno-suppressant therapy).

4. Non-covered expenses will include:
   (a) any financial consideration to a donor other than expenses directly related to the performance of the surgery,
   (b) any animal organ or mechanical organ,
   (c) anything excluded or limited as stated in the Plan.

Additional Covered Benefits. In addition to the standard organ transplant benefit (See Schedule of Benefits), the following benefits may be available when a covered person participates in the Plan's Organ Transplant Program. This Organ Transplant Program is an enhancement to the standard organ transplant benefit and participation in the program is voluntary. Additional covered benefits include:

1. Access to over forty (40) "Transplant Centers of Excellence" across the United States, as well as outpatient peripheral stem cell facilities and transplant facilities in Great Britain;
2. Reimbursement for travel and lodging expenses incurred during the transplant procedure immediately prior to and after the transplant up to a $10,000 maximum for the covered person and a companion. Travel and lodging discounts are also available with select airlines and hotels;
3. Waiver of the covered person's deductible and out-of-pocket expenses up to a maximum of $1,500; and
4. Services of a transplant facilitator who will coordinate the entire transplant process.

The services listed above are only available when a covered person fully participates in the Organ Transplant Program and meets all of the following requirements:

1. Pre-certification of the proposed organ transplant must be made by the covered person or the physician as soon as the covered person is identified as a potential transplant candidate. **Pre-certification is made by calling Primary PhysicianCare at 1-800-472-5001**; and
2. All organ transplant services must be rendered at a "Transplant Center of Excellence" facility in the Transplant Program Network. Primary PhysicianCare will coordinate selection of the facility with the patient and physician.

If these requirements are not met, Organ Transplant Program benefits may be reduced.

Once enrolled in the program, a transplant facilitator will be assigned. This facilitator will coordinate the entire organ transplant process with the patient and physician, from hospital selection to travel arrangements to prescription drug options. Information regarding the network hospitals and other relevant information will be forwarded to the covered person and the physician. The transplant facilitator will work with the covered person, the physician, and the Plan Supervisor to assure quality and continuity of care throughout the process, pre-transplant to post-transplant, including organ harvest.

COORDINATION OF BENEFITS

Coordination of Benefits. When two (2) or more plans cover the incurred expenses, coordination of benefit rules will apply to determine the order in which those plans pay for covered charges. When a covered person is covered by this Plan and another plan, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the coordination rules is the primary plan and will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total allowable expenses.

Benefit Plan. The Plan will coordinate medical and dental benefits provided under another benefit plan. The term "benefit plan" includes any one of the following plans:

1. Group or group-type plans, including franchise or blanket benefit plans;
2. Blue Cross and Blue Shield group plans;
3. Group practice and other group pre-payment plans;
4. Federal government plans or programs, including Medicare and Medicaid;
5. Other plans required or provided by law; or
6. No fault auto insurance, by whatever names it is called, when not prohibited by law.

Allowable Charges. For a charge to be allowable it must be a Reasonable & Customary charge and at least part of it must be covered under this Plan.

In the case of health maintenance organization (HMO) plans, this Plan will not consider any charges in excess of what an HMO provider has agreed to accept as payment in full. In addition, when an HMO pays its benefits first, this Plan will not consider as an allowable charge any charge that would have been covered by the HMO had the covered person used the service of an HMO provider.

In the case of service type plans, where services are provided as benefits, the reasonable cash value of each service will be the allowable charge.

When coverage of medical expenses is available under an automobile insurance policy, **coverage under** this Plan is **limited** to covered expenses in excess of those available under the automobile insurance policy, without reimbursement for any deductibles under the automobile insurance policy. This Plan always shall be the secondary plan regardless of the individual's election under PIP (personal injury protection) coverage with the automobile insurance carrier.

Benefit Plan Payment Order. When two or more plans provide benefits for the same allowable charge, benefit payment will follow these rules:

1. Plans that do not have coordination provisions will pay first. Plans with coordination provisions will be considered after those without them.
2. Plans with coordination provisions will pay benefits in accordance with the following rules, whichever applies first, up to the allowable charge:

    (a) The plan that covers the person directly, as an employee, member, or subscriber, (Plan A) pays before the plan that covers the person as a dependent (Plan B). **Special Rule.** If (i) the person covered directly is a Medicare beneficiary and (ii) Medicare is secondary to Plan B and (iii) Medicare is primary to Plan A (for example, if the person is retired), then Plan B will pay before Plan A.

    (b) A plan which covers a person as an employee who is neither laid-off nor retired (or as a dependent of such employee) pays before a plan which covers that person as a laid-off or retired employee (or as a dependent of such laid-off or retired employee). If the other benefit plan does not have this rule, and if, consequently, the plans do not agree on the order of benefits, this rule does not apply.

    (c) A plan which covers a person as an employee who is neither laid-off nor retired (or as a dependent of an employee who is neither laid-off nor retired) pays before a plan which covers the person as a COBRA beneficiary.

    (d) When a child is covered as a dependent and the parents are not separated or divorced, these rules will apply:

        (i) The plan of the parent whose birthday falls earlier in a year pays before the plan of the parent whose birthday falls later in that year; and

        (ii) If both parents have the same birthday, the plan that has covered the patient for the longer time pays before the plan that covers the other parent.

    (e) When a child is covered as a dependent and the parents are divorced or legally separated, these rules will apply:

        (i) If there is a court decree that establishes that one parent is financially responsible for the health care expenses of the child, the plan of that parent will be considered before other plans that cover the child as a dependent.

        (ii) If there is a court decree that states that the parents share joint custody of the child without stating that one of the parents is financially responsible for the child's health care expenses, then the plans will apply the birthday rules outlined under (d) above to determine which plan is primary.

(iii) If there is no court decree, then:
(A) If the parent with custody of the child has not remarried, the plan of the parent with custody will pay before the plan of the parent without custody.
(B) If the parent with custody of the child has remarried, the plan of the parent with custody will be considered first. The plan of the stepparent that covers the child as a dependent will be considered next. The plan of the parent without custody will be considered last.

(f) If there is still a conflict after these rules have been applied, the plan that has covered the patient for the longer time, will be considered primary.

3. Medicare will pay primary, secondary, or last to the extent required by federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled in both of these parts.

Claims Determination Period. Benefits will be coordinated on a calendar year basis. This is called the claims determination period.

Right to Receive or Release Necessary Information. This Plan may give or obtain needed information from another insurer or any other organization or person for purposes of coordinating benefits. This information may be given or obtained without the authorization of or notice to the person that is the subject of the information. When you file a claim for benefits, you must indicate any other plans under which you and/or your dependents are covered, and you must provide this Plan any information requested about those plans and their payment of allowable charges.

Facility of Payment. This Plan may repay other plans for benefits paid by the other plans that the Plan Administrator determines should have paid by this Plan. That repayment will count as a valid payment under this Plan.

Right of Recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case, this Plan may recover the amount paid from the other benefit plan or from the covered person. That repayment will count as a valid payment under the other benefit plan. In addition, this Plan may pay benefits that are later found greater than the allowable charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

PLEASE NOTE: If you have other health coverage from any other source where coordination is allowable, including Medicare, Medicaid, and TRICARE coverage, the co-insurance limit does not apply.

COBRA CONTINUATION COVERAGE

Federal law gives certain persons the right to continue Plan coverage beyond the date it would otherwise terminate. The entire cost (plus an administration fee allowed by law) must be paid by the continuing person. Continuation coverage will end if the covered individual fails to make timely payment of the required contribution or premium. This law is referred to as "COBRA," which stands for the Consolidated Omnibus Budget Reconciliation Act of 1985.

What COBRA Provides

COBRA coverage is available to you and your covered dependents, if coverage under the Plan would otherwise end because:

- Your employment with the Employer ends for any reason other than gross misconduct; or
- Your regularly scheduled work hours are reduced so that you no longer meet the Plan's eligibility requirements.

In addition, COBRA coverage is available to your covered dependents if their coverage would otherwise end because of:

- Your death, divorce, legal separation; or
- Your entitlement to Medicare; or
- Your dependent child ceased to be eligible for Plan coverage (for example, due to age or loss of full-time student status).

The Employer filing a proceeding in bankruptcy under title 11 of the United States Code also can be a qualifying event for you and your covered dependents, but only if you are a retired employee covered under the Plan at the time and the bankruptcy results in loss of coverage under the Plan.

Under COBRA, "qualified beneficiaries" – you and your eligible covered dependents – may continue the same coverage they had before the COBRA qualifying event. If coverage for similarly situated active employees or their dependents is modified, your COBRA coverage will be modified in the same manner.

A child born to you, adopted by you or placed for adoption with you during the period of COBRA continuation coverage will be entitled to receive coverage under the Plan for the duration of your COBRA coverage period. You must enroll the child within 30 days of the birth, adoption or placement for adoption, otherwise you will have to wait until the next annual open enrollment period to enroll the child.

Maximum COBRA Continuation Period

If elected, COBRA coverage begins as of the date Plan coverage would otherwise end. The maximum duration of COBRA continuation varies depending on the reason you or your covered dependents are eligible for COBRA.

For Up to 18 months. Coverage may continue for you and your covered dependents for **up to 18 months** if coverage under the Plan would otherwise end because of a reduction in work hours or termination for reasons other than gross misconduct.

For Up to 29 months. If the Social Security Administration determines that you or a covered dependent is disabled within 60 days of the date your coverage ends due to a reduction in hours or termination of employment, COBRA coverage for the disabled individual and non-disabled family members entitled to COBRA may be continued for **up to 29 months** from the date of the qualifying COBRA event. You must notify the Plan Administrator in writing of the disability within 60 days after the latest of: (a) the Social Security's determination of disability, (b) the date on which the qualifying event occurs, or (c) the date on which you are notified of the requirement to provide the notice of disability. You also must notify the Plan Administrator within 30 days if Social Security Administration determines that the disabled individual is no longer disabled. Notices about disability must be provided to the Employer and/or the Plan Administrator in writing at the address listed in the Plan Information section.

For Up to 36 Months. COBRA coverage may continue for your covered dependents for **up to 36 months** if their coverage would otherwise end because of (1) your death, divorce or legal separation, (2) your entitlement to Medicare, or (3) your dependent child ceasing to be eligible for Plan coverage. If any of these qualifying events occurs while your dependents are covered under COBRA due to an event resulting in 18 months of COBRA coverage (see above), coverage may continue for a total of 36 months from the date of the first COBRA qualifying event, but only if the second qualifying event would have caused your covered dependent to lose coverage had the first qualifying event not occurred. To extend coverage, you or your dependents must notify the Employer and/or the Plan Administrator within 60 days of the second qualifying event, as described below.

You Must Give Notice of Some Qualifying Events

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. If the qualifying event is termination of employment, reduction in hours, death, or your entitlement to Medicare, the Employer must notify the COBRA Administrator within 30 days of such event.

However, for other qualifying events (divorce, legal separation, or a dependent child's loss of eligibility), you or your dependents must notify the Employer and/or the Plan Administrator within 60 days of the qualifying event or the date coverage would terminate due to that event, whichever is later. If notice is not provided within this time limit, COBRA continuation coverage will not be available to your dependents. The COBRA Administrator will notify you in writing if COBRA continuation is not available after one of these qualifying events.

In addition, if while covered under COBRA for 18 months, your spouse or dependents experience a second qualifying event that allows extension of COBRA coverage to 36 months, you or your dependents must notify the Plan Administrator within 60 days of the second qualifying event. Failure to provide timely notice will result in loss of eligibility for the extension on account of the second qualifying event.

Required notices of qualifying events must be provided to the Employer and/or the Plan Administrator at the address listed in the "Plan Information" section.

How to Elect COBRA Coverage

Once notified that a qualifying event has occurred, the COBRA Administrator will notify qualified beneficiaries in writing that they have the right to elect COBRA and will send the appropriate election forms. Each qualified beneficiary will have an independent right to elect COBRA. Covered employees may elect COBRA on behalf of their spouses, and parents may elect COBRA on behalf of their children.

Qualified beneficiaries must elect COBRA within 60 days after the date coverage would otherwise end or, if later, within 60 days of the date they receive the COBRA notice from the COBRA Administrator.

Paying for COBRA Coverage

Qualified beneficiaries who elect to continue coverage under COBRA are required to pay 102% of the full cost of coverage. If COBRA continuation coverage is extended due to disability, COBRA payments will equal 150% of the full cost of coverage beginning on the 19th month of COBRA coverage.

The first payment for COBRA coverage must be made within 45 days after the date of the COBRA election and must be retroactive to the date regular coverage ended. Thereafter, COBRA payments are due on the first day of each calendar month and must be received within 30 days of the due date. If payments are not timely received, COBRA coverage will be terminated retroactive to the last day for which payment was received.

Special COBRA Rules for TAA-Eligible Employees

The Trade Act of 2002 created a new tax credit for employees who become eligible for trade adjustment assistance ("TAA") because their employment is adversely affected by international trade. Under these new provisions, TAA-eligible individuals can either take a tax credit or get advance payment of 65% of the premiums for COBRA coverage.

To assist TAA-eligible individuals in taking advantage of this tax credit or advance payments, the Trade Act provides them a special second COBRA election period. Therefore, if you lose Plan coverage as a result of a TAA-related event and you do not enroll in COBRA at the time, once the IRS determines that you are TAA-eligible, a second COBRA election period will be available to you and your covered dependents. This second election period begins on the first day of the month in which you are determined to be TAA-eligible, provided your election is made no later than six months after the date you lose coverage as a result of the TAA-related event. COBRA coverage elected during this second election period will be effective as of the first day of the election period, not the date as of which your coverage first lapsed. The cost will be the same as described above for other COBRA coverage.

If you have questions about TAA eligibility, you may call the Department of Labor Employment and Training Administration toll-free at 1-877-US-2JOBS. For questions about the health coverage tax credit, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282.

Termination of COBRA Coverage

COBRA continuation coverage will terminate before the end of the maximum period on the earliest of:

1. The date that the Employer ceases to provide a group health plan to any of its employees;
2. The date after the COBRA election date that the qualified beneficiary first becomes:
   (a) Entitled to benefits under Medicare; or
   (b) Covered under any other group health plan as an employee or otherwise. However, a qualified beneficiary who becomes covered under a group health plan which has a pre-existing condition exclusion will be allowed to continue COBRA coverage for the length of the pre-existing condition exclusion or to the COBRA maximum time period, if less. COBRA coverage may be terminated if the qualified beneficiary becomes covered under a group health plan with a pre-existing condition exclusion, if the pre-existing condition exclusion does not apply to or is satisfied by the qualified beneficiary by reason of the portability, access and renewal requirements of the Health Insurance Portability and Accountability Act ("HIPAA").
3. The date the qualified beneficiary fails to pay the cost of COBRA coverage by the due date (including the applicable grace periods); or
4. For a qualified beneficiary who has extended COBRA coverage of 29 months due to disability, COBRA coverage will end as of the month that begins at least 30 days after a final determination has been made by the Social Security Administration that the disabled individual is no longer disabled.

The COBRA Administrator will notify qualified beneficiaries in writing in the event COBRA coverage is terminated before the end of the applicable maximum continuation period.

Keep Plan Informed of Address Changes

In order to protect your family's COBRA rights, you should keep the Plan Administrator informed of any changes in the addresses of covered family members.

Questions About COBRA

If you have any questions about COBRA continuation coverage, please contact the COBRA Administrator.

THIRD PARTY LIABILITY

Right of Reimbursement

Sometimes, a covered person may incur expenses for a condition or injury (such as from a car accident) that someone else is legally responsible to pay. While such expenses are not covered under this Plan, the Plan may advance payments for such expenses. As a condition to the Plan advancing payments for any condition or injury for which a third party is liable, the covered person shall agree to reimburse the Plan in full from any funds recovered from that third party (which may be an individual, a company or an insurer). The amount to be reimbursed to the Plan will equal the payments advanced by the Plan, without any adjustment for the covered person's attorney fees and costs to obtain payment from the third party, but will not exceed the amount received from the third party.

Any recovery from a third party as the result of a judgment, settlement, or otherwise, by or on behalf of a covered person, shall be deemed to be held in trust for the benefit of the Plan until reimbursement, to the extent of the payments advanced by the Plan. Any funds recovered from the third party shall be applied first to reimburse the Plan for any and all payments made under the Plan for that covered person, regardless of the following:

1. The amount of damages claimed by the covered person against the third party or whether the covered person has been made whole for such damages;
2. Any characterization of the payments by the third party with respect to the covered person's damages, such as personal injuries, future education or training or, pain and suffering; or
3. The covered person recovering the funds or property being a minor.

If the covered person receives funds from the third party and does not promptly reimburse the Plan, future benefits may be reduced to cover the amount of payments advanced by the Plan.

Right of Subrogation

In addition to the right to reimbursement, if the Plan advances payments for a condition or injury that another party is responsible for paying, the Plan will be subrogated to the covered person's right to recover from the third party. This means that the Plan may assume the rights of the covered person to file a lawsuit or make a claim against the party whose acts or omissions caused the condition or injury.

The Plan Administrator may in its sole and complete discretion determine whether or not to pursue the Plan's right of subrogation.

Pursuing Reimbursement and Subrogation

As a condition to receiving payments from the Plan, covered persons shall agree to fully assist and cooperate with the Plan Administrator in protecting and obtaining the Plan's reimbursement and subrogation rights, including, but not limited to, promptly furnishing the Plan Administrator with information concerning the person's right of recovery from any third party, and, if requested, executing and returning any reimbursement or subrogation-related documents. The covered person shall further agree not to allow the Plan's reimbursement and subrogation rights to be limited or prejudiced by any acts or omissions by the covered person. In the event of any such acts or omissions by the covered person, the Plan Administrator shall be authorized in its sole discretion to suspend or terminate the payment or provision of any further benefits to or for the benefit of the covered person.

FILING CLAIMS

CLAIM FILING PROCEDURE

It is the responsibility of the covered person to see that doctor bills, medical bills, and hospital charges are submitted to the Plan Supervisor. Claim forms may be obtained from the Human Resources Office at your location. Claim forms must be filled out completely. Claims must be submitted to the Plan Supervisor at:

Primary PhysicianCare, Inc.
Attention: Claims Department
PO Box 11088
Charlotte, North Carolina 28220-1088
(704) 523-2758

Benefits are paid to the employee/covered person unless the physician agrees to accept the payment directly or there is a valid assignment of the right to receive payment permitted under the terms of the Plan. The following items are important and should be submitted with each claim.

1. If a physician has not completed a billing statement form, the covered person must obtain a claim form from the Human Resources Office for completion.
2. All physicians' bills must include the following:
   (a) Name of patient;
   (b) Date and charge for office visit(s);
   (c) A complete and accurate diagnosis;
   (d) Current Procedural Terminology (CPT) code(s);
   (e) Provider's Federal ID Number or social security number; and
   (f) Complete current address of physician, including zip code and telephone number.
3. Claims for medication or drug expenses must include the following:
   (a) Name of person for whom drug was prescribed;
   (b) Prescription number and name of drug;
   (c) Cost of medication and date of purchase (cash receipts, canceled checks, or credit card receipts cannot be accepted for consideration);
   (d) Name of physician prescribing drug; and
   (e) For generic drugs, the prescription receipt marked GENERIC by pharmacist;
4. Copies of all other covered charges, such as for registered nurses and supply houses, must include the following:
   (a) Name of patient;
   (b) Date and charge for visit(s);
   (c) Nature of treatment or services rendered;
   (d) Federal ID Number or social security number of provider; and
   (e) Complete diagnosis.

Report claims promptly. **The deadline for filing a claim for any benefit is twelve (12) months after the date that the expense is incurred. If the covered person fails to file a claim within this time period, the claimed expenses will not be covered under the Plan.**

INITIAL CLAIMS PROCESSING

Following is a description of how the Plan processes claims for benefits. A claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant, that complies with the Plan's procedure for making benefit claims, as described here.

There are different kinds of claims and each one has a specific timetable for approval, payment, denial, or request for further information. If you have any questions regarding the claims procedure, please contact the Plan Supervisor.

Post-Service Claims

Post-Service Claims are those filed for payment of benefits after medical care has been received. If your Post-Service Claim is denied, you will receive a written notice from the Plan Supervisor not later than thirty (30) days after receipt of the claim, if all needed information was provided with the claim. Sometimes additional time is necessary to process a claim due to circumstances beyond the control of the Plan. If an extension is necessary, the Plan Supervisor will notify you in writing within the thirty (30) day period of the reasons for the extension and the date by which it expects to render a decision. The extension generally will be no longer than fifteen (15) days, unless additional information is needed.

If the extension is necessary because you failed to provide all needed information, the notice of extension will describe the additional information required. You will have forty-five (45) days to provide the additional information. If all the needed information is received within that time limit and the claim is denied, the Plan Supervisor will notify you of the denial within fifteen (15) days after the information is received. If you do not provide the needed information within the forty-five (45) day period, the Plan Supervisor may decide the claim without that information.

A notification of denial will include:

- The specific reason(s) for the denial;
- Reference to the specific Plan provisions on which the determination is based;
- A description of any additional material or information necessary to perfect the Claim and an explanation of why such material or information is necessary;
- A description of the Plan's appeal procedures and of your right to bring a civil action under federal law following the denial of an appeal;
- A statement disclosing any internal rule, guideline, protocol, or similar criterion referenced in making the adverse benefit determination (or a statement that such information will be provided free of charge upon request); and
- If the denial is based on a medical necessity or experimental treatment or similar exclusion, an explanation of the scientific or clinical judgment for the adverse benefits determination (or a statement of such explanation) will be provided free of charge upon request.

Pre-Service Claims
Pre-Service Claims are those claims that require notification or approval prior to receiving medical care (for example, non emergency hospitalizations and surgery). If your Pre-Service Claim is submitted properly with all needed information, the Plan Supervisor will send you a notice of the benefit determination, whether adverse or not, no later than fifteen (15) days from receipt of the claim.

If you fail to file a Pre-Service Claim in accordance with the Plan's procedures, the Plan Supervisor will notify you of the improper filing, and how to correct it, within five (5) days after the improper claim is received.

If an extension is necessary to process your Pre-Service Claim, the Plan Supervisor will notify you in writing within the initial fifteen (15) day response period, and may request a one-time extension of up to fifteen (15) days. If the extension is necessary because you failed to provide all needed information, the notice of extension will describe the additional information required. You will then have forty-five (45) days to provide the additional information. If all the needed information is received within that time limit, the Plan Supervisor will notify you of the determination within fifteen (15) days after the information is received. If you do not provide the needed information within the forty-five (45) day period, the Plan Supervisor may decide the claim without that information.

A denial notification will include the information listed here for Post-Service Claim details.

Urgent Care Claims
Urgent Care Claims are those that require notification or approval prior to receiving medical care, and where a delay:

- Could seriously jeopardize your life or health or your ability to regain maximum function, or
- In the opinion of a physician with knowledge of your medical condition, could cause you severe pain.

If you file an Urgent Care Claim in accordance with the Plan's procedures and include all needed information, the Plan Supervisor will notify you of the determination, whether adverse or not, as soon as possible, but no later than seventy-two (72) hours after receipt of the Urgent Care Claim. However, if you fail to follow the Plan's procedures, the Plan Supervisor will notify you of the improper filing and how to correct it within twenty-four (24) hours of receipt of the improper claim. This notification may be oral, unless you request a written notification.

If you fail to provide all the information required to decide your claim, the Plan Supervisor will notify you of the additional information needed within twenty-four (24) hours after receipt of the claim. You will then have forty-eight (48) hours to provide the requested information. You will be notified of the determination on your claim no more than forty- eight (48) hours after the earlier of the following:

- The Plan Supervisor's receipt of the requested information, or
- The end of the forty-eight (48) hours given to you to provide the requested information.

A denial of an Urgent Care Claim will include the information listed here for Post-Service Claim denials. Notifications regarding urgent Care Claim determinations may be oral, with written or electronic confirmation to follow within three (3) days.

Concurrent Care Claims
There are two types of Concurrent Care Claims:

- A claim to extend coverage for a course of treatment beyond a previously approved period of time or number of treatments, or
- A claim regarding reduction or termination of coverage by the Plan before the end of a previously approved period of time or number of treatments.

You must submit a request to extend an ongoing course of treatment at least twenty-four (24) hours before the end of the previously approved limit. If your request for extension is made timely and involves Urgent Care, the Plan Supervisor will notify you of the determination, whether adverse or not, within twenty-four (24) hours after the claim is received. If your claim is not made at least twenty-four (24) hours prior to the end of the previously approved limit, the request will be treated as an Urgent Care Claim (not a Concurrent Care Claim) and decided according to the timeframes described here for Urgent Care Claims. A request to extend coverage that does not involve urgent care will be considered a new claim and will be decided according to the Post-Service or Pre-Service timeframes described here, as applicable.

If an ongoing course of treatment previously approved by the Plan is denied for continued coverage, the Plan Supervisor will notify you sufficiently in advance to allow you to submit an appeal.

Notices regarding denials of Concurrent Care Claims will include the information listed for Post-Service Claim denials.

Questions About Claim Determinations
If you have questions or concerns about a determination on your claim, you may contact the Plan Supervisor to inquire about it. This often clears up questions about benefit determinations, what the Plan covers, or what services were actually provided. You can reach the Plan Supervisor by calling the telephone number on your ID card or by writing to the address indicated above. A representative of the Plan Supervisor's Claims Department will be available to answer your questions about the claim. If the Plan Supervisor cannot resolve the issue to your satisfaction, you can proceed with a formal appeal as described below. Remember that you are not required to contact the Plan Supervisor informally. If you are not satisfied with a benefit determination, you may appeal it immediately by indicating that you are filing a formal appeal.

APPEALS

To appeal a denial of a claim, you must submit a request for appeal in writing to the Plan Administrator at the address indicated in the notice of denial.

NOTE: If you are appealing an Urgent Care Claim denial, please refer to the Urgent Care Appeals section below and call the Plan Supervisor immediately at the number indicated on your ID card.

How to File an Appeal

You have one hundred eighty (180) days from receipt of the notice of denial to file an appeal. Except for appeals involving Urgent Care (See Urgent Care Appeals), appeals must be in writing and must be sent to the address specified in the notice of denial. You may submit comments, documents, and other information in support of your claim. The review on appeal will consider any information you submit, even if it was not submitted for or considered as part of the initial determination. Also, upon request and free of charge, you will be provided reasonable access to and copies of all documents, records, and information that are relevant to your claim.

A document, record, or other information shall be considered relevant to a claim if it:

- was relied upon in making the benefit determination;
- was submitted, considered, or generated in the course of making the benefit determination;
- demonstrates compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or
- constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

Determinations on Appeal

The review on appeal will afford no deference to the initial benefit determination. Someone other than the individual involved in the initial benefit determination or a subordinate of that individual will be appointed to decide the appeal.

If your claim was denied based on a medical judgment (such as whether a service or supply is Medically Necessary, Experimental or Investigational), the Plan Administrator will consult with a health professional with appropriate training and experience. The health care professional consulted for the appeal will not be a professional (if any) consulted during the initial determination or a subordinate of that professional. The Plan Administrator also will identify medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, even if the advice was not relied upon in making the benefit determination.

The Plan Administrator will provide you with written or electronic notification of the determination on appeal as follows:

- *For appeals of Pre-Service Claims*, not later than thirty (30) days after receipt of the appeal.
- *For appeals of Post-Service Claims*, not later than sixty (60) days after receipt of the appeal.

If your appeal is denied, the notification will include:

- The specific reason(s) for the denial;
- Reference to the specific Plan provisions on which the determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to or copies of all documents, records, or other information relevant to the claim;
- A description of any voluntary appeal procedures offered by the Plan and a statement of your right to bring civil action under Federal law;
- A statement disclosing any internal rule, guideline, protocol, or similar criterion referenced in making the adverse determination (or a statement that such information will be provided free of charge upon request); and
- If the denial on appeal is based on a medical necessity or experimental treatment or similar exclusion, an explanation of the scientific or clinical judgment for the adverse benefits determination (or a statement that such explanation will be provided free of charge).

Urgent Care Appeals

An appeal involves Urgent Care and requires immediate action if a delay could significantly increase the risk to your health or impairs your ability to regain maximum function or, in the opinion of a physician with knowledge of your condition, could cause you severe pain.

If your appeal involves Urgent Care, the appeal does not need to be submitted in writing. You or your physician should call the Plan Supervisor immediately at the number indicated on your ID card. The Plan Supervisor will notify you of the determination on your appeal as soon as possible, but not later seventy-two (72) hours after receipt of the appeal. The notification may be written or electronic and will include the information described here for other appeal denials.

Voluntary Level of Appeal
The Plan offers a voluntary level of appeal that may include mediation or arbitration. Claimants may submit a benefit dispute to this voluntary appeal only after exhaustion of the appeals process described in the Appeals section.

If the claimant elects the voluntary level of appeal, any statute of limitations or other defense based on timeliness will be tolled during the time the voluntary appeal is pending. In addition, the Plan shall not assert that a claimant has failed to exhaust administrative remedies by not electing to submit the benefit dispute to the voluntary appeal provided by the Plan.

The Plan will provide to the claimant, upon request and at no cost, sufficient information about the voluntary appeal process to enable the claimant to make an informed judgment on whether or not to submit a benefit dispute to the voluntary level of appeal. This information will include a statement that the decision will have no effect on the claimant's rights to any other benefits under the Plan, will list the rules of the appeal, will state the claimant's right to representation, will enumerate the process for selecting the decision maker, and will give circumstances, if any, that may affect the impartiality of the decision maker.

No fees or costs will be imposed on the claimant as part of the voluntary level of appeal, and the claimant will be so informed.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

Plan Administrator. The Plan Sponsor may appoint an individual or a committee to serve as Plan Administrator of the Plan. If the Plan Administrator resigns, dies, or is otherwise removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

If the Plan Sponsor does not otherwise appoint a Plan Administrator, the Plan Sponsor shall be the Plan Administrator.

The Plan Administrator is required to administer this Plan in accordance with its terms and has the authority to establish policies and procedures for the management and operation of the Plan. It is the express intent of this Plan that the Plan Administrator shall have sole and complete discretionary authority to construe and interpret the terms and provisions of the Plan, to decide issues regarding eligibility and benefits due under the Plan, and to make all determinations, including factual determinations, arising under the Plan. Except as otherwise required by law, the decisions of the Plan Administrator will be final and binding for all interested parties.

Duties of the Plan Administrator. The Plan Administrator's duties include:

1. To administer the Plan in accordance with its terms;
2. To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies, or omissions;
3. To settle disputes which may arise relative to a participant's or beneficiary's rights;
4. To prescribe procedures for filing claims for benefits and to review claim denials;
5. To keep and maintain the Plan documents and all other records pertaining to the Plan;
6. To appoint a claims administrator to process and pay claims;
7. To perform all necessary reporting as required by Federal Law;
8. To establish and communicate procedures to determine whether a medical child support order is qualified; and
9. To delegate to any person or entity such powers, duties, and responsibilities, as it deems appropriate.

Plan Administrator Compensation. The Plan Administrator serves without compensation from the Plan Sponsor. However, all administrative expenses of the Plan, including compensation for services contracted from third parties in connection with the Plan, will be paid by the Plan Sponsor.

Fiduciary. A fiduciary is anyone who (i) exercises discretionary authority or control over the management of the Plan or the management and disposition of Plan assets; (ii) renders investment advice to the Plan; or (iii) has discretionary authority or responsibility in the administration of the Plan.

Fiduciary Duties. A fiduciary must carry out his or her duties and responsibilities solely in the interest of participants and beneficiaries:

1. For the exclusive purpose of providing benefits to employees and their dependents and defraying reasonable expenses of administering the Plan.
2. With the care, skill, prudence, and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation; and

The Named Fiduciary. A "named fiduciary" is the Plan Administrator. The named fiduciary can appoint others to carry out fiduciary responsibilities other than as Plan trustees. These other persons become fiduciaries themselves and have fiduciary responsibility for their acts under the Plan. To the extent that the named fiduciary allocates fiduciary responsibilities to other persons, the named fiduciary shall not be liable for any act or omission of those persons unless:

1. The appointment was imprudent or the named fiduciary fails to monitor the conduct and performance of the appointee; or
2. The named fiduciary breached his or her fiduciary responsibility.

Plan Supervisor Is Not a Fiduciary. The Plan Supervisor is not a fiduciary under the Plan by virtue of processing and paying claims in accordance with the Plan's rules as established and interpreted by the Plan Administrator.

A participant or beneficiary shall not rely on any oral statement from any employee or customer representative of the Plan Supervisor to:

1. Modify or otherwise amend the benefits, limitations and exclusions or other provisions of this Plan;
2. Increase, reduce, waive or void any coverage or benefits under this Plan.

Any statement by the Plan Supervisor should not be interpreted as a guarantee of coverage or payment for any services rendered or otherwise provided to a participant or beneficiary.

GENERAL INFORMATION

PLAN AMENDMENTS AND TERMINATION
The Plan Sponsor reserves the right to modify, amend or terminate the Plan completely or in part. The Plan may be amended or terminated by formal action of the board of directors of the Plan Sponsor or by appropriate action of any person(s) authorized to act on behalf of the board of directors of the Plan Sponsor.

If the Plan, or any benefit offered under the Plan, is amended, modified or terminated, the rights of covered persons are limited to covered charges incurred before the effective date of that amendment, modification or termination. Covered persons will be informed of any changes that affect their coverage.

ASSIGNMENTS
Benefits under the Plan may not be voluntarily or involuntarily assigned or alienated, provided, that payment of benefits of a covered person will be made directly to a physician, hospital or other provider furnishing services to the extent that the covered person has authorized such physician, hospital or other provider to receive direct payment of benefits due under the Plan. Assignment of benefits for any purpose other than direct payment to providers shall not be permitted and shall not be binding on the Plan, the Plan Administrator or the Employer.

CLERICAL ERROR & MISSTATEMENTS
Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered. If any relevant information as to the amount of coverage shall have been misstated, the facts will determine whether or not, and how much, coverage is in force.

OVER PAYMENTS
If a member or any other person or entity receives a benefit payment that exceeds the amount of benefits payable under the Plan, the Plan has the right to either (i) require that you or the person or entity that was paid return the amount of the overpayment or (ii) reduce any future benefit payments to you or your dependents by the amount of the overpayment. This right does not affect any other right of recovery concerning the overpayment.

PLAN IS NOT AN EMPLOYMENT CONTRACT
The Plan is not a contract of employment, and participation in the Plan does not guarantee any person's employment with the Employer.

PRIOR COVERAGE PROVISION

This provision applies only to a person who was covered on the date this Plan first became effective and who was covered under the prior plan, which this Plan replaced.

1. **Pre-existing Conditions.** Benefits for pre-existing conditions will be equal to the lesser of:
   a. benefits payable under the prior plan had it remained in effect; or
   b. benefits payable under this Plan.

   If any person is eligible for continuation of coverage under the prior plan, benefits under this Plan will be limited to only those eligible expenses not eligible for payment under continuation of coverage under the prior plan.
2. **Deductible.** This Plan will allow credit toward the deductible for any portion of the calendar year deductible that the covered person satisfied under the prior plan.

PRIVACY RIGHTS UNDER HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that the Plan protect the confidentiality of your private health information. A description of your privacy rights under HIPAA can be found in the Plan's Notice of Privacy Practices provided upon enrollment.

Uses and Disclosures of Protected Health Information
This Plan will not use or disclose your individually identifiable health information protected by HIPAA ("protected health information") except as necessary for treatment, payment, and other health care operations, or as permitted or required by law. In particular, the Plan will not, without authorization, use or disclose protected health information to your Employer for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of your Employer. The Plan also requires all of its business associates (as that term is defined by HIPAA) to observe HIPAA's privacy requirements.

The Employer, as sponsor of the Plan, hereby agrees to comply with HIPAA requirements to the same extent as the Plan is required to comply. Your Employer will limit access of PHI to certain classifications of employees and only for certain permitted purposes (as described below), will report any violations of HIPAA privacy requirements of which it becomes aware, and has implemented procedures for handling noncompliance.

Protected health information may be disclosed to and used by human resources, benefits, finance/accounting and information technology employees of the Employer who are responsible for carrying out administrative functions for the Plan – for example, benefit determinations, benefit payments, and claims audits. However, these employees will only have access to the information on a "need to know" basis and will use and disclose only the minimum necessary protected health information to accomplish the intended Plan administration purpose.

The Plan also may use or disclose protected health information about individuals covered under the Plan in communications with family members involved in the care or payment of health care of that individual, if relevant to such involvement. In addition, the Plan may disclose protected health information if required by law or for certain public health and national priority purposes, including: (1) as authorized and necessary to comply with workers' compensation laws, (2) in response to a subpoena or other valid legal process, (3) to health oversight agencies and public health authorities, and (4) to authorized government officials for intelligence and national security activities authorized by law.

Your Individual Rights
Under HIPAA, you have certain rights with respect to your protected health information:

Right to access, inspect and obtain copies of your protected health information. You have the right to access and copy protected health information about you contained in a designated record set maintained by the Plan. To request access to or copies of your protected health information, you must send a written request to the Plan's Privacy Official listed in the Plan Information section at the beginning of this booklet. Within 30 days of receipt of your written request (or 60 days if the information is not maintained on-site), the Privacy Official will inform you whether your request was granted or denied. The Plan may provide you with a summary or explanation of the protected health information instead, if you agree or request such summary or explanation. You may be charged a reasonable, cost-based fee for copying, postage and preparing a summary or explanation.

Right to request amendments of protected health information if incorrect. If you feel that any protected health information the Plan maintains about you is incorrect, you may request that the Plan amend it. A request for amendment must be submitted to the Privacy Official in writing. Your request must state the reason for the requested amendment. Within 60 days after receipt of the request (90 days, if an extension is necessary, and you are notified of the extension prior to the expiration of the initial 60-day period), the Privacy Official will either accept or deny the amendment request and notify you of the basis of any denial. If your request is denied, in whole or in part, you will have the right to submit a written statement of disagreement or to request that the amendment request and the denial be included in any future disclosures of the information. If you submit a statement of disagreement, the Plan may prepare a rebuttal.

Right to request additional restrictions on uses and disclosures of your protected health information. You may request additional restrictions on the Plan's uses and disclosures of your protected health information when the information is used for purposes of carrying out treatment, payment or health care operation activities, or to persons involved in your care or payment of your health care. Your request must be submitted to the Privacy Official in writing. The Plan does not have to agree to such additional restrictions.

Right to request communications of protected health information by alternative means or at alternative locations. You may request that the Plan communicate with you about your protected health information only by certain methods or at a different address, provided that you furnish a clear statement, which indicates that communicating the information by the usual means or at the usual location would endanger you. To request alternative communications, you must submit a written request to the Privacy Official. The Plan will accommodate reasonable requests to the extent practicable.

Right to receive an accounting of certain disclosures of protected health information. You have the right to request an accounting of certain disclosures the Plan has made of your protected health information after the effective date of the HIPAA privacy rules. The accounting will exclude disclosures for treatment, payment, and health care operations; disclosures to you or authorized by you; disclosures to family members or other persons involved in your care or payment of your care; and disclosures for certain national security purposes. To request an accounting you must submit a written request to the Privacy Official. The first accounting you request within a 12-month period will be free of charge, but you may be charged for additional accountings.

Right to file complaints. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services ("HHS") if you believe your privacy rights under HIPAA have been violated. Complaints to the Plan should be filed with the Privacy Official listed in the Plan Information section at the beginning of this booklet.

SCHEDULE OF VISION BENEFITS FOR HIGH OPTION PLAN

(Vision Coverage Not Available Under The Standard Option Plan)

Vision Benefits	
Routine eye exams	Payable at 100% after a $20 co-pay per visit
Vision supplies including frames, lenses and contact lenses	Payable at 100% up to a calendar year maximum of $250. Benefit only available once every two years

VISION ELIGIBILITY PROVISIONS

New employees will be eligible for Vision coverage on the first day that all Eligibility Requirements for Employee Coverage have been met in section entitled ELIGIBILITY in this document.

COVERED VISION EXPENSES

1. The eligible vision charges referred to above are those charges made for services, supplies, and treatments performed by a legally qualified ophthalmologist or optometrist.
2. Medical and surgical treatment of the eye is not covered under the Vision Benefits. Eligible expenses are limited to routine refractive error and corrective lenses and frames (including contact lenses). If lenses are necessary due to a medical condition or injury, expenses will not be eligible under the Vision Plan.